STATE TITLE V BLOCK GRANT NARRATIVE
STATE: MO
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

By signing the Application Face Sheet (Standard Form 424) the Director of the Division of Administration of the Department of Health and Senior Services assures compliance with the certifications and assurances for non-construction programs, debarment and suspension, drug-free workplace, lobbying, Program Fraud Civil Remedies Act (PFCRA), and environmental tobacco smoke. The signed original Standard Form 424 is being submitted to Title V Block Grant, HRSA Grants Application Center. A copy of the signed Standard Form 424 and certifications and assurances may be obtained from Division of Community Health, Missouri Department of Health and Senior Services, P.O. Box 570, 930 Wildwood Drive, Jefferson City, Missouri 65102-0570. The certifications and assurances are attached to this section.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public input was an essential element in the development of this application. The process for obtaining public comments included newspaper ads placed in ten strategic newspapers across the state; hard copies mailed to key stakeholders throughout the state; article placed in weekly electronic newsletter "Friday Facts" prepared by Center for Local Public Health Services (CLPHS) (http://www.dhss.mo.gov/fridayfacts/); Proposed Use of Funds document placed on the Department's Web site (www.dhss.mo.gov) and electronic notification of location of Proposed Use of Fund sent to Department of Health and Senior Services (DHSS) management and all 114 local public health agencies (LPHAs).

Responses received from maternal and child health stakeholders throughout the state were reviewed and incorporated into the plan where appropriate. In addition to the 17 responses received, the DHSS Web site with the Proposed Use of Funds had a total of 153 hits, internally and externally.

For the 2005 Needs Assessment, the University of Missouri-Kansas City, Institute for Human Development, directed 12 focus groups across Missouri between July and September of 2004 to generate qualitative research input. Ten groups consisted of health consumers (two conducted among Latino consumers). Two groups consisted of providers. Targeted populations were women of childbearing age, adolescents, parents/caregivers, and families of children with or without disabilities.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

A.1. DEMOGRAPHIC PROFILE

Selected demographic information from U.S. Census Bureau for Missouri can be located under Section II, Needs Assessment under B. Five Year Needs Assessment, 3.1. MCH Demographic Overview. It compares Missouri's population with the United States in regard to age, race/ethnic distribution, and educational attainment. Further, 3.2. Benchmark Analysis provides a comparison of maternal and child health related indicators among states similar to Missouri.

Based upon "Growth in the Heartland: Challenges and Opportunities for Missouri" by the Center on Urban and Metropolitan Policy at the Brookings Institution report copyrighted 2002, Missouri grew in the 1990s but significant growth has stalled since 2000. The state's population decentralized with the population and job gains moving beyond metropolitan areas. With the decentralization came the increase in the capital and operation costs for roads, sewer and water infrastructure, schools, and police and fire services; a serious water quality problem in the Ozark lakes due to septic seepage; damage to Ozark lakes and landscapes which threaten a $1.6 billion tourist industry; high-capacity roads in need of building and maintenance; and isolation of low income and minority Missourians from opportunity as middle-class residents and employment move out to suburban/rural areas.

"Growth in the Heartland" concluded that while Missouri had enjoyed enviable growth in the nineties, and many new residential communities had sprouted up during that decade, a slowing economy in the new century raises many questions concerning how best to support the needs of communities that are increasingly dispersed geographically. Missouri's metropolitan areas are all experiencing the "open country" shift of their core populations shrinking as growing numbers of residents leave the central city and even older suburban areas for newer residential developments away from urban congestion.

Missouri is the 17th largest state in the nation based on the 2000 Census. In the year 2000, Missouri's population was 5,595,211; by 2003, the total population of Missouri was 5,704,484. Of the total Missouri population in 2000, it was estimated that 84.9% of persons living in Missouri were white; 11.2% were African American, and 3.9% were of other racial groups. It was estimated that in 2003 there were 130,928 Hispanics living in Missouri, an increase of 9.3% over 2000 census numbers; the total percentage of whites living in Missouri increased slightly by 1.2% during this time period; and the percentage of African-Americans within the total population had increased by 3.6% from the 2000 census. In 2000, the percentage of the population who were Asian/Pacific Islander increased 55.1% since 1990 from 41,758 to 64,773 in 2000. By 2000, American Indian/Alaskan Native population grew 24% from 1990 to just under 5.6 million in 2000.

In Missouri, the population of women of childbearing age in 2000 was 1,206,615. In 2005, that population is estimated to decrease by slightly more than two percent to 1,181,916. Most of this decrease is in the 35-44 year old age cohort. Between 1998 and 2003, the number of live births among whites increased by 1.9% and the number of births among African-Americans for the same period declined by 3.1%. Between 1998 and 2003, the total number of births in Missouri increased from 75,242 to 76,960. During this period of time, the number of births among mothers eligible for Medicaid increased from 28,847 (38.3% of total births) to 33,436 (43.5% of total births).

The size of the under age five group shrank from 11% of the state's total population in 1960 to 6.6% in 2000. Population forecasts predict it will shrink to an estimated 6.3% in 2020, to 382,000 children, fully 84,000 less than in 1960. The 5-13 age group also declined dramatically between 1960 and 2000, falling from 17% to 12.8% of the total population. By 2020, this age group will number an estimated 689,000 or 110,000 less than in 1960 due to an aging population and couples having fewer children. The 15-17 age group is somewhat larger than it was in 1960, numbering an estimated 304,000 persons in 2005. This age group is projected to fall to 292,000 persons in 2020.

In 2002, the percentage of population below poverty level was 9.9%. In 2002, the percentage of school-age children below poverty level was 15.3%.

In 2000, the percent of children under 18 in Missouri that had limited English language proficiency was approximately 0.6% of the total population under age 18. Geographically, children with limited English language proficiency are situated along the I-70 corridor, around Kansas City and St. Louis, and in extreme southwest Missouri.

A.2. CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Missouri participated in the first National Survey of Children with Special Health Care Needs that was conducted as a module of SLAITS. Based upon this survey, there are an estimated 215,818 (15%) children in Missouri that have special health care needs.

Information from SLAITS Summary Tables from the National Survey of Children with Special Health Care Needs, 2001, shows the national average percentage of:
-CSHCN with adequate health insurance coverage was 59.6 while Missouri's was 66.0;
-CSHCN who receive ongoing, comprehensive care within a medical home was 52.6 while Missouri's was 55.7.

In addition, the national percent of CSHCN needing specific health services:
-for prescription medicine was 87.9 while Missouri's was 90.6;
-for Dental Care was 78.2 while Missouri's was 78.8;
-for prevention care was 74.4 while Missouri's was 72.0;
-for specialist care was 51.0 while Missouri's was 52.4;
-for eyeglasses/vision care was 35.6 while Missouri's was 37.1; and
-for mental health care was 25.4 while Missouri's was 28.9.

Like CSHCN services most commonly reported in other states as NEEDED but NOT received, Missouri reported dental care, mental health care, and specialist care as needed but not received. The charts and tables with these details are available in 3.3.3. Children with Special Health Care Needs of the Needs Assessment along with more charts and tables.

A.3. MIGRATION PATTERNS

An assessment of Missouri's migration patterns by CHIME revealed the following findings (see maps in 3.1.4. Migration Patterns of the Needs Assessment):

"Missouri's population increased by 478,138 persons (9.3%) during the 1990-2000 decade ……. More than double the growth of the 1980's (200,307). This was the largest increase, both in terms of actual persons and percentage growth, in the past 70 years. However, Missouri was below the national population increase of 13.2% and ranked 30th among all states in terms of percentage increase. Of particular note, was the dramatic change in migration during the 1990-2000 time period. The net migration increase of 258,458 persons was far greater than anything Missouri had experienced in the recent past. Missouri had been at the break-even level of suffered net-migration losses of greater than 100,000 persons every decade going back to the 1930s. The large changes in migration during the decade of the 1990s fueled the doubling of Missouri's population growth rate. As geographical shifts in Missouri's population were analyzed for this assessment, it is clear that the composition of Missouri's population is increasingly more diverse. Minorities drove much of Missouri's population growth in the nineties and early part of the new century. 'Between 1990 and 2000, the proportion of Hispanics and other persons of color in this state grew from 13.1 percent to 16.2 percent to reach a total of 908,737 Missourians.' Missouri's minority residents now account for fully half of this state's population growth over the last decade. The Hispanic population in Missouri nearly doubled during the last decade, as that minority population grew from 61,702 residents in 1990 to 118,592 in 2000. In summary, Missouri's population (including all MCH population groups) increased by relatively large amounts during the past ten years with the rate of growth slowing during the economic recession

beginning in 2000. In absolute terms, Missouri had the highest population increase of the past 50 years. In terms of percentage growth, Missouri migration matched the high water marks of the 1950s and 1960s. The difference between the 1950s era growth was that for the former decade, growth was bolstered by high birth rates; for the latter, it was the result of much higher migration totals. At the county level, Missouri had many fewer counties lose population through migration this decade, compared to the 1980s. However...the Kansas City and St. Louis metropolitan areas, the older central segments (Jackson County, St. Louis County and St. Louis City) all suffered losses in terms of net migration, while many of the suburban counties surrounding them had relatively high in-migration rates..."

A.4. NEEDS ASSESSMENT METHODOLOGY

The State's overall needs assessment methodology included but was not limited to the following methods:

-Review of Missouri state profiles compiled by Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), and Association for Maternal and Child Health Programs (AMCHP) to ascertain external perspectives of MCH needs in Missouri

-Qualitative primary data generated through 12 focus groups conducted throughout Missouri divided into two cohorts: client (user) group cohort and provider or agency group cohort

-Review of Community Health Technical Assistance, Resources and Training (CHART) survey of local coalition members, state and county profiles (with selected MCH indicators and related priorities) generated by the Center for Health Information Management and Evaluation (CHIME) and local public health priorities formulated by the Center for Local Public Health Services (CLPHS)

-MCH population group(s) forecasts developed from demographic data drawn from the U.S. Census and from analysis provided by the Missouri State Demographer's Office

-Composite analysis of selected MCH indicators to compare (county by county) the relative MCH health status of women and children living in different geographical regions in Missouri: infant mortality, unintended pregnancies (teenage pregnancies), tobacco use among mothers during pregnancy, STDs among women of childbearing age, abortions, obesity, percentage of MCH population groups with insurance coverage

-Data provided by the Missouri Department of Social Services (DSS), Missouri Department of Mental Health (DMH), Missouri Primary Care Association (MPCA), and other professional associations concerning the infrastructure capacity (in Missouri) to deliver basic health services to MCH population groups

-Nominal group process used by selected MCH stakeholders to suggest possible MCH priorities for Missouri WHERE Stakeholders reviewed a draft version of the assessment presented in this application, reflected upon their own experiences, and applied the following criteria in delineating MCH priority need areas for Missouri:

Criterion 1--Degree to which need can be impacted by known effective interventions

Criterion 2--Degree of health-related consequence(s) of not addressing need

Criterion 3--Degree of state and national support other than Title V for impacting need

Criterion 4--Degree of current demographic disparity regarding need (e.g. race, gender, income, place of residence)

Criterion 5--Degree to which other local providers or service consumers identify need as a high MCH

priority

The accumulated information and analysis identified the following immerging issues:

-Adequacy of Primary Care
-Reduction of Obesity
-Domestic Abuse (Violence Against Women)
-Use/Abuse of Tobacco Among Youth
-Mental Health Services for MCH Populations
-Early Childhood Development and Education
-Cigarette Smoking (Tobacco Use) Among Pregnant Women
-Adequate Dental Health Network Capacity

A.5. MISSOURI MCH PRIORITIES

The priorities for the MCH populations identified by the 2005 Needs Assessment are listed below according to levels of service.

A.5.1. MCH Infrastructure

Support Adequate Early Childhood Development and Education in Missouri - Collaborate to coordinate efforts through a leadership role in an interagency coalition for the purpose of better targeting existing resources for early childhood development and education, identifying gaps in service delivery and infrastructure, and pursuing necessary resources to address these identified areas.

Improve the Mental Health Status of MCH Populations in Missouri - Collaborate with state and local partners to transition our state mental health service delivery system to a public health model through a variety of avenues, including our leadership role in a multi-agency Comprehensive Children's Mental Health System planning and implementation process; technical assistance to school communities implementing CDC's School Health Index and transition to use of Coordinated School Health model; and a focus on the prevention aspect of mental health and substance abuse issues, particularly in relation to pregnant women, children, and adolescents.

Enhance Environmental Supports and Policy Planning/Development for the Prevention of Chronic Disease - Provide technical assistance and support to local, state, and regional initiatives to develop or enhance environmental supports and/or policies aimed at addressing the three primary risk factors for the development of chronic disease: nutrition, physical activity and tobacco use/secondhand smoke. Emphasis will be placed upon environmental supports and policies that focus upon the development of positive lifestyle choices and habits and decrease chronic disease for the next generations.

A.5.2. POPULATION-BASED MCH SERVICES

Reduce Interpersonal/Domestic Violence Among MCH Populations - Continue to advocate for primary prevention to reduce interpersonal violence, as well as provide technical assistance and resources to local and regional partners to implement primary prevention planning in their respective areas using evidence-based approaches.

Prevent and Reduce Smoking Among Adolescents and Women - Collaborate with statewide partners to reduce the number of women who smoke during pregnancy using evidence-based practice.

Reduce Obesity Among Children, Adolescents, and Women - Collaborate with statewide partners to achieve healthy weight among an increased percentage of children and adolescents through increased physical activity and healthy eating habits.

Reduce Disparities in Birth Outcomes - Collaborate with state and national partners to examine the intransigent causes and correlations to poor birth outcomes to allow focused interventions and initiatives. Implement and evaluate these resultant interventions and initiatives to decrease racial/ethnic, geographical, and socioeconomic disparities related to low birth weight, prematurity, prenatal care received, and infant mortality.

Reduce Intentional and Unintentional Injuries among Infants, Children, and Adolescents in Missouri - Collaborate with statewide partners to implement environmental supports and local, regional, and state policies to positively impact motor vehicle accidents/deaths among adolescents; suicide attempts/completions among adolescents; and intentional/unintentional injuries among infants and children.

A.5.3. DIRECT/ENABLING MCH SERVICES

Improve Access to Care - Provide technical assistance and resources in collaboration with other statewide partners to assure adequacy and cultural competency of provider networks which support reproductive health, primary health, oral health, and mental health/substance abuse services for women, infants/children, adolescents, and special health care need populations, with an emphasis on medical/oral health home.

Reduce and Prevent Oral Health Conditions Among MCH Populations in Missouri - Collaborate with statewide partners to identify and address gaps in oral health service delivery system; conduct oral health surveillance to inform the oral health systems enhancement initiatives; support the training and placement of oral health professionals in underserved areas to better meet the oral health needs of MCH populations in Missouri; encourage the integration of oral health preventive services into primary care and school health settings.

B. AGENCY CAPACITY

B.1. State Statutes

On March 29, 1883, the Missouri Legislature established a state agency responsible for the promotion of the people's health and the prevention of disease by creating a State Board of Health. Through the years, reorganizations have resulted in Missouri Crippled Children's Service becoming a part of the then Division of Health in 1974. The Department of Health (DOH) was created July 29, 1985, and was officially empowered and charged with supervising and managing all public health functions and programs formerly administered by DOH. In 2001, Executive Order 01-02 transferred the Division of Aging to DOH and formed the Department of Health and Senior Services (DHSS) allowing one department to more effectively focus on prevention and quality of life for all Missourians.

Missouri statutes that relate to maternal and child health (MCH) and Children with Special Health Care Needs' (CSHCN) authority are primarily found in Chapter 191 -- Health and Welfare and Chapter 201 -- Crippled Children of the Missouri Revised Statutes (RSMo).

In 2004, funding was appropriated to allow dental hygienists to bill Medicaid/SCHIP for services rendered under the expanded scope of practice as defined in RSMo 332.311 which allows a duly registered and currently licensed dental hygienist with at least three years of experience, practicing in a "public health setting", to provide Medicaid eligible children: fluoride treatments, teeth cleaning, sealants, if appropriate, without the supervision of a dentist.

Section 630 of the RSMo incorporates Senate Bill 1003 (Child Mental Health Reform Act) to create a Comprehensive Children's Mental Health Service System to serve children with emotional and behavioral disturbance problems, developmental disabilities, and substance abuse problems. By August 28, 2007, and periodically thereafter, the Children's Services Commission shall conduct an evaluation of the implementation and effectiveness of the Comprehensive Children's Mental Health Service System, including an assessment of family satisfaction and the progress of achieving

outcomes.

B.2. CAPACITY AND COLLABORATION

The Missouri Title V agency, DHSS Division of Community Health (DCH), takes the lead responsibility and/or collaborates with other State agencies, local communities, and private organizations in developing, implementing, and supporting policies and services to ensure a statewide system of services that provide for pregnant women, mothers, infants, children, and children with special health care needs. The following are offices, units, and programs located within DHSS that contribute to that system with information regarding their collaboration with other agencies and entities. See DHSS Web page for description of all services provided by DHSS at www.dhss.mo.gov/AboutDHSS/Directory_of_Services.pdf.

B.2.1. DEPARTMENT DIRECTOR'S OFFICE is responsible for the management of the department and the administration of its programs and services. The deputy directors of health and public health and senior services and regulation assist the director in the management of the department. Offices and centers reporting to the director include CHIME, Office of Minority Health and Senior Services, Office on Women's Health, and Office of Epidemiology.

B.2.1.1. Center for Health Information Management and Evaluation (CHIME) is responsible for the statistical vital records and information systems of the DHSS; advises DHSS on the general health status of Missourians based on analysis of health statistics; is custodian of birth, death and other vital records; and provides such health-related statistical services as Web-based Community Health Profiles and Missouri Information for Community Assessment (MICA).

B.2.1.2. Office of Minority Health and Senior Services addresses CULTURAL COMPETENCY; monitors the impact of all programs in DHSS on the health status of minority populations in Missouri; assists in the coordination and development of educational programs and culturally sensitive minority health education materials designed to reduce the incidence of disease in the state's minority populations; assists community minority health organizations by identifying funding for health programs through public and private grants; promotes coalition and community development resources; and addresses access and disparity health issues.

B.2.1.3. Office On Women's Health in DHSS is supported by Title V funding and exists to integrate an awareness of women's health issues and concerns into planning for all DHSS programs and services, coordinate existing activities related to the health of girls and women, and promote broader, more effective collaboration related to women's health issues.

B.2.1.4. Office of Epidemiology provides epidemiologic leadership and expertise for divisions and centers at DHSS, LPHAs, as well as other stakeholders and partners to enhance the health and safety of the citizens of Missouri. Many of its activities are integrated with Office of Surveillance, Evaluation, Planning and Health Information.

Office of Epidemiology is using the Perinatal Period of Risk Approach (PPOR) model in collaboration with DCH to identify high risk infant mortality/pre-maturity target areas and with MCH coalition partners to better focus resources through a STD study and the oral health studies.

B.2.2. CENTER FOR LOCAL PUBLIC HEALTH SERVICES (CLPHS) adds value to the state public health system by supporting a population-based approach to health issues in Missouri communities and provides leadership and technical assistance to local public health agencies to help develop processes to improve community-based public health systems. These processes, such as strategic planning, continuous quality improvement, and implementing the ten essential public health services, aid in developing, and communicating a common vision and direction for public health in Missouri.

B.2.3. DIVISION OF SENIOR SERVICES AND REGULATION's Bureau Of Child Care (BCC) in the Section for Health Standards and Licensure (HSL) is responsible for the licensing of facilities and

quality initiatives such as Nurse Consultation and inclusion services to improve health, safety, and overall quality.

Title V Block Grant funds are used to enhance Child Care Resource and Referral (R&R) services for families and children with special health care needs. Through this project the Child Care R&R has qualified inclusion staff in every R&R agency to provide statewide-enhanced services listed below:
-Determination of need for enhanced services for children with special needs.
-Development of a plan of action, in collaboration with the family, to support child care services to a child with special needs.
-Referral of all families of children with special needs to Missouri's Early Intervention Programs (First Steps), local Public School District, or other appropriate programs or services.
-Offering of technical assistance to licensed, licensed-exempt, and unlicensed child care providers on how to provide quality care for children with special needs in an inclusive setting.
-Support of community-based training to licensed, licensed-exempt, and unlicensed child care providers regarding inclusive child care.
-Support of community awareness of the importance of inclusive child care.

Funds are also used to support activities of Child Care Health Consultants to consult with and educate child care providers regarding issues around the care of children with special health care needs.

B.2.4. DIVISION OF COMMUNITY HEALTH (DCH) is responsible for maternal, child, and family health; nutritional health; chronic disease prevention and health promotion; community health improvement; and surveillance and planning. DCH is also the Missouri Title V agency. Its components directly related to the programs follow.

B.2.4.1. Office of Surveillance, Evaluation, Planning and Health Information (OSEPHI), supports DCH in strategic planning; quality improvement initiatives; program evaluations; coordination of specific grants (including MCH Title V and SSDI); public information dissemination; initiation and maintenance of surveillance systems, data management and reporting; and epidemiologic consultations and assistance. Key MCH-related surveillance systems supported by OSEPHI are:

-Behavioral Risk Factor Surveillance System Program
-Cancer Registry Program
-Pediatric Nutrition Surveillance System
-Pregnancy Nutrition Surveillance System Program
-Pregnancy Related Assessment Monitoring System

B.2.4.2. Section of Chronic Disease Prevention and Health Promotion (CDPHP) directs statewide programs designed to combat major causes of premature death, illness, disability, and medical costs such as heart disease, cancer, stroke, diabetes, and arthritis. These programs are conducted through four units: Cancer and Chronic Disease Control (CCDC); Health Promotion (HP); Primary Care and Rural Health (PCRH); and Community Food and Nutrition Assistance (CFNA) Programs.

B.2.4.2.1. HP oversees programs and initiatives to reduce tobacco use, physical inactivity, and unhealthy eating primary risk factors for chronic diseases, including obesity. The unit supports local programs through contracts, training, and technical assistance in implementing evidence-based strategies to reduce risk factors.

B.2.4.2.2. PCRH works to ensure access to and availability of primary health care services for all of Missouri's populations. PCRH's Oral Health Program (OHP) provides a broad range of core public health activities: oral health care, oral health surveillance, oral health education, technical assistance to communities on community water fluoridation campaigns, promotion of dental sealants, and oral health research. It serves as a resource on oral health issues for other states and federal agencies, the dental profession, and the public. Initiatives include: Elks Mobile Dental Program, Fluoride Mouthrinse (FMR) Program, Oral Health Screening and Surveillance, and Water Fluoridation

Program.

The Elks Mobile Dental Program made primary clinical and preventative dental services available to special health care needs and other vulnerable children populations. In FFY 2004, treatment was provided to 2,366 eligible children (including children with special health care needs) in over 3,052 encounters. FFY 2001 has the baseline of 1,556 children receiving treatment in over 2,406 encounters.

During FFY 2003, 80% of the population on public water systems were on fluoridated public water systems. The baseline for Missouri public water systems optimally fluoridated water was 74% in FFY 2001. OHP has begun a new cooperative effort with Department of Natural Resources (DNR) to better monitor and intervene with public water systems that are fluoridated but not maintaining optimal level of fluoridation.

OHP is developing a cadre of Registered Dental Hygienists in communities around the state to aid in development of oral health interventions and to act as liaisons with communities, health professionals, and schools in regard to oral health issues, including public water fluoridation. These health professionals will champion public water fluoridation in those communities seeking to fluoridate water systems or those facing efforts to discontinue.

B.2.4.3. Section for Maternal, Child and Family Health (MCFH) contains Healthy and Safe Families (HSF); Special Health Care Needs (SHCN); Genetics and Newborn Health (GNH); and WIC and Nutrition Services (WIC/NS) which manage key MCH units and programs.

B.2.4.3.1. HSF contains the programs addressing adolescent health, school health, interpersonal injury and violence prevention, and MCH coordinated systems.

Adolescent Health Program uses state and federal funds to contract for adolescent medicine consultation and educational programs for adolescents, parents, professionals, and communities to improve the overall health status of adolescents. Council for Adolescent and School Health (CASH) advises the DHSS in assessing adolescent health needs and in planning effective strategies to promote protective factors and reduce risks to the health of adolescents.

Title V funding is used to promote abstinence-only education through schools and community-based organizations to educate adolescents to delay involvement in sexual activity until marriage and to decrease out-of-wedlock pregnancies, adolescent pregnancy and birth rates, and sexually transmitted diseases.

School Health Program is a collaborative effort of DHSS, Department of Elementary and Secondary Education (DESE), and DSS. Contracts are provided to public school districts and LPHAs to establish or expand population-based health services for school-age children in defined geographic areas. The program focus is on increasing access to primary and preventive health care. An effort is made to assure an adequate nurse to student ratio.

Maternal and Child Health (MCH) Coordinated Systems distributes federal Maternal and Child Health Services Block Grant funds to LPHAs through its MCH services contract to maintain and improve the health status of maternal and child populations in Missouri by establishing and maintaining an integrated multi-tiered service coordination system (direct care, enabling, population-based, and infrastructure building) capable of adapting to address targeted MCH issues. Each contractor has a contractual obligation to utilize evidence-based interventions and address identified MCH risk indicators, which are the most disparate from the state rates. In FFY 2004, there were 109 contracts with LPHAs with community specific interventions with over 250 short-term outcomes to reach the Healthy People 2010 objectives.

The MCH and the School Health Programs initiated development of a statewide conference to target MCH and School Health contractors. The conference's focus is to increase capacity of contractors for

evidence-based practice, build community collaboration, improve social marketing skills, improve evaluation practices, and strengthen cultural competency.

Injury Prevention Program develops public policy, coordinates injury prevention interventions, collaborates with other agencies addressing injury causes, and supports the collection and analysis of injury data. It also contracts with each of the eight local SAFE KIDS Coalitions to conduct primary injury prevention interventions including safety fairs, car seat installation demonstrations and inspections, and training for other safety professionals. The injury prevention program also contracts with the University of Missouri to conduct the Think First Missouri Educational Program to provide primary prevention activities addressing the prevention of head and spinal cord injury.

Sexual Assault Forensic Evaluation-Child Abuse Resource and Education (SAFE-CARE) Network is composed of physicians and nurse practitioners trained to provide comprehensive, state-of-the-art medical evaluations to alleged victims of child sexual assault. The program responds to the need for a coordinated, effective response to child sexual assault and utilizes electronic linkages between SAFE-CARE Network providers to improve medical consultation in rural and underserved areas.

Interpersonal (Domestic) Violence is addressed by technical assistance, resources, literature, and educational opportunities being provided to health care professionals and to the general public to assist them in understanding domestic violence and related issues and promoting strategies to prevent domestic violence.

B.2.4.3.2. Special Health Care Needs (SHCN) in DCH develops, promotes, and supports community-based systems that enable the best possible health and highest level of functioning for Missourians with special health needs.

SHCN is organized into four life-stage programs: infants and toddlers, children, adolescents, and adult transition. Each life-stage program is supported by services which involves:

1. State program collaboration with other State agencies and private organizations,
2. State support for communities,
3. Coordination of health components of community-based systems, and
4. Coordination of health services with other services at the community level

Family Partnership (FP) is implemented through a contract between SHCN and one LPHA for FP statewide activities. FP: provides families with the opportunity to offer each other support and information; gives families the opportunity to provide SHCN input regarding the needs of individuals with special needs; increases public awareness of issues facing families of individuals with special needs; builds community awareness of the unique needs of individuals with disabilities; and promotes state legislation for programs for individuals with special needs and their families. FP members are parents, legal guardians, or siblings of individuals with special health care needs. At each meeting, the FP group is trained or given information on topics pertinent to their needs as families of special needs individuals. Family Partners provide outreach activities to encourage participation in the FP meetings.

Children with Special Health Care Needs (CSHCN) Service Coordination is provided through LPHAs with whom SHCN maintains contracts for 13 regions throughout the state for participants/families to receive service coordination from individuals located within the participant's region and very knowledgeable about local services. SHCN provides continual training, mentoring, and technical assistance opportunities for the contracts and monitors the contracts to assure quality.

Contracted Service Coordinators complete Comprehensive Assessment Tools (CATs), Service Plans, and Transition Plans with participants/families to address specific needs and services available to assist in the achievement of the best possible health and highest level of functioning for SHCN participants. The CAT, completed on an annual basis with participants/families, assists in identification of participant/family needs, determines if the participant/family has a medical home; and

is uniquely designed to address each life-stage needs.

Needs identified by the participant/family and Service Coordinator are outlined in the development of the Service Plan which is also completed with participants/families on an annual basis. It identifies: concerns, priorities, and resources of the participant/family; outcomes or changes the participant/family wants to occur; services needed to address the identified outcomes; method, duration, and location of services; service providers; funding resources to cover the cost of the services; and the effective date for the initiation of services. A Service Plan is developed from the information obtained during the assessment process and is a ‘blue print' for how services will be provided to meet the needs of the participant/family.

Transition Plans are completed by Service Coordinators with participants/families and team members to address the needs of participants and referral timelines as they: transition from one life-stage to another, discontinue from a service, or transition to a new Service Coordinator or agency.

Contracted Service Coordinators conduct outreach activities to identify children with special health care needs. They utilize the CSHCN Screener as a tool to identify children in the general population who have special health care needs. Contracted Service Coordinators participate in interagency meetings and promotional functions to educate the public about issues for individuals with special health care needs and increase knowledge of SHCN services.

Administrative Case Management is provided by a cooperative agreement SHCN maintains with DSS/DMS (Medicaid). SHCN authorizes the medical necessity of in-home nursing services and provides Service Coordination for participants of the following programs:

-Healthy Children and Youth (HCY, Missouri's name for the federal EPSDT program) for participants under the age of twenty-one and
-Physical Disabilities Waiver (PDW) for participants over the age of twenty-one.

All Missouri Medicaid recipients under the age of twenty-one (21) are eligible to receive HCY Services. SHCN Service Coordinators may approve Advanced Personal Care Services, Personal Care Services, Private Duty Nursing, and HCY Case Management and provide Service Coordination that links families with services and resources to help families maintain the HCY participant safely in their home. Assistance provided includes: help with establishing a medical home; referrals for periodic EPSDT Screening Exams; referrals to physicians, therapists, home health agencies, and services; regular home visits to assess family needs; and assistance in assuring that appropriate medical care is being provided through Medicaid.

PDW is limited to people who have received, or would have qualified for, Private Duty Nursing through the HCY Service prior to their twenty-first birthday. PDW is designed to allow participants who turn twenty-one to stay in their home with ongoing support, similar to what they were receiving, or would have qualified for, through the HCY Service prior to their twenty-first birthday. PDW provides approval for medically necessary services that are identified by SHCN Service Coordinators.

Adult Head Injury Service Coordination is provided through contracts SHCN maintains with LPHAs and the University of Missouri at Mount Vernon to provide Service Coordination for Missouri residents over the age of 21 and have survived a traumatic brain injury (TBI). Service Coordination provided includes: evaluation and assessment of needs; information and education regarding the causes and effects of TBI and prevention of secondary conditions; development of a Service Plan; regular evaluation and updates of the Service Plan; assistance in locating and accessing medical care, housing, counseling, transportation, rehabilitation, vocational training, and cognitive/behavior training.

To address cultural competency, SHCN has a contract with Institute for Human Development (IHD) to provide professional training and awareness that will increase cultural-competency of SHCN staff, members, and providers. Also provided will be the identification of Hispanic families that have children with special health care needs or other disabilities to assist with training and serving their needs. The

quarterly newsletters are mailed in both English and Spanish and also uploaded to the Family Partnership Web site. By continuing to monitor the changing demographics of populations in the State of Missouri and identifying areas in which to assist with cultural training and serving specific needs of various cultural groups, SHCN will be better prepared to meet the needs of participants and provide services in a culturally competent manner. CSHCN Nutrition Training has increased competence of professionals providing nutrition services for children with special health care needs, including integration of the most current evidence-based guidelines for standards of practice or of "best practices" in the delivery of services, increased confidence, and increased cultural competence.

Insurance coverage information was gathered from different perspectives. DESE, DMH, DSS, managed care organizations (MCOs), and Systems of Care Board collaborated to obtain information about children with special health care needs that transition within the systems of care and identify gaps in insurance coverage for the special needs population as did FQHCs and LPHAs who also conducted surveys to establish processes for participants/families to apply for Medicaid to assist in reducing the gaps in coverage.

Department of Insurance, DSS (Medicaid and MC+ Health Care), Medical Assistance for Families (MAF), Family Partnership, and Medical Assistance for Workers with Disabilities (MAWD) developed an insurance glossary, comparison checklist, and fact sheet to assist participants/families in making choices related to insurance. These materials are available on the SHCN Web site and are distributed to participants/families.

Resource Index, a comprehensive resource index of healthcare and community service providers by life-stage and county, was developed by SHCN using community resources, such as the Chamber of Commerce Web site, and in collaboration with Family Partners, contracted Service Coordinators, and Community Connections. SHCN will identify partners of collaboration and coordinate with other existing efforts to reduce duplication of similar efforts focused on developing and maintaining resource information.

SHCN participates in local, regional, and state disaster response planning activities to represent the needs of SHCN participants. Service Coordinators discuss emergency preparedness with participants/families to encourage the development of emergency response plans, to be updated annually. This information is maintained within each Area Office to be available during time of an emergency. Local emergency response personnel have been notified of the availability of the information.

CSHCN Screening Tools are provided to Service Coordinators, WIC clinics, LPHAs, conferences, health fairs, school health nurses, and other medical and school professionals to identify children with special health care needs. SHCN will investigate other children's health care screeners and determine if any collaboration is needed with individuals and agencies that either develop or utilize these screeners so that the system is accessible to families and children with special health care needs without being duplicative.

SHCN Provider Enrollment of approved providers for medical care and ancillary services for participants enrolled in the Hope Service and the Adult Head Injury Service makes the provider enrollment forms available on the Internet. Provider licenses are verified on the Internet prior to enrollment to assure that the licenses are current. SHCN maintains provider enrollment information in the MOHSAIC system for availability to Service Coordinators and emails contracted Service Coordinators to inform them of new and discontinued providers.

B.2.4.3.3. Genetics and Newborn Health's Genetics Services Program expands and develops new programs where needed to reduce the morbidity and mortality associated with genetic disorders. Information is provided to the public and medical professionals regarding genetic disorders and availability of genetic services in Missouri. A referral network is maintained for individuals in need of diagnostic services, treatment, counseling, and other genetic-related services.

Newborn Blood Spot Screening Program provides early identification and follow-up of phenylketonuria (PKU), galactosemia, congenital hypothyroidism, congenital adrenal hyperplasia and hemoglobinopathies that suggest the presence of disease in affected, but as yet, asymptomatic infants to ensure that either a repeat newborn screen or a confirmatory test has been done. Infants found to be positive are referred to a system of health care. Additional conditions to be identified are being added July 2005.

Newborn Hearing Screening Program began in 2002 for all babies born in Missouri to have their hearing tested before hospital discharge. The program seeks to screen every baby before three months of age and refers those with hearing loss to the First Steps Program by six months of age. The program's newborn hearing screening informational brochure for parents has been translated into Spanish and Bosnian.

Folic Acid Program's develops, disseminates, and evaluates nutrition education materials and information to increase the number of Missourians who know that folic acid intake helps prevent certain birth defects, diseases, and health conditions.

Breastfeeding Program provides technical assistance and training and educational materials to health providers and the general public regarding breastfeeding and prenatal nutritional supplementation appropriate for all infants to improve the health of infants and their mothers.

Home Visiting Programs' services include: nurse health assessment for postpartum mothers and newborns; assessment for risk factors associated with child abuse and neglect; education on infant/child health and development, nutrition, safety, parenting/family support; and referrals through case management. Building Blocks of Missouri in the Southeast and Kansas City regions of Missouri is a prenatal and early childhood nurse home visiting program based on the David Olds' Model (Nurse-Family Partnership). Missouri Community-Based Home Visiting utilizes the Families at Risk model developed by University of Missouri/Sinclair School of Nursing, in collaboration with DHSS.

Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP) is a collaboration between state government, academic researchers, service providers, and medical professionals who are working together to reduce the number of alcohol-exposed pregnancies and ultimately reduce the number of children diagnosed with Fetal Alcohol Syndrome (FAS).

The Missouri Fetal Alcohol Syndrome Action and Care Team (MOFASACT) and the MOFASRAPP had been linked creating collaborative efforts to maximize resources.

Fetal and Infant Mortality Review (FIMR) analyzes infant and fetal death records to develop recommendations for community change, if appropriate, to reduce fetal and infant mortality. The communities then determine and implement interventions based upon recommendations received that may improve outcomes for future families.

B.2.4.4. WIC and Nutrition Services focus is to decrease preventable nutrition-related morbidity and mortality throughout the life cycle. The programs coordinated by this unit focus on assuring Missourians found to be "nutritionally at-risk" receive nutritious food supplements through local grocery vendors or farmer's markets.

C. ORGANIZATIONAL STRUCTURE

DHSS has streamlined DCH's operations to more effectively serve women, infants, children, and adolescents in Missouri. DCH is responsible for maternal, child, and family health; nutritional health; chronic disease prevention and health promotion; and programs for community health improvement. DCH is also responsible for the preparation of Maternal and Child Health (MCH) Services Block Grant annual plan and application. Director of DCH serves as Director of the state's Title V program, as well as Director of the state's Children with Special Health Care Needs (CSHCN) program.

Section III. State Overview, B. Agency Capacity, contains more detailed information regarding the sections and programs. The DHSS Web page provides access to the Directory of Services with descriptions for all services of DHSS at http://www.dhss.mo.gov/AboutDHSS/Directory_of_Services.pdf.

Organizational charts for the State, DHSS, and DCH are located in the attached file to illustrate the hierarchy of the government and the state agencies and are maintained on file. The following is a brief outline for the DCH hierarchy.

Department of Health and Senior Services Director
---Department of Health and Senior Services, Health and Public Health Deputy Director
------Division of Community Health (DCH) Director
.....DCH Deputy Director
.....DCH Chronic Disease Prevention and Health Promotion (CDPHP), Section Administrator
.....DCH Maternal, Child and Family Health (MCFH), Section Administrator
.....DCH Office of Surveillance, Evaluation, Planning and Health Information (OSEPHI), Section Administrator
.....DCH Office of Fiscal Support (OFS), Section Administrator

CDPHP contains:
-Cancer and Chronic Disease Control (CCDC)
-Health Promotion (HP)
-Primary Care and Rural Health (PCRH)
-Community Food and Nutrition Assistance Programs (CFNA)

MCFH contains:
-Healthy and Safe Families (HSF)
-Special Health Care Needs (SHCN)
-Genetics and Newborn (GNH)
-WIC and Nutrition Services (WIC/NS)

OSEPHI contains:
-Quality Improvement, Planning, and Evaluation (QIPE)
-Community Health Information (CHI)
-Surveillance and Epidemiology (SE)

HSF, SHCN, and GNH located within MCFH serve as the principal operating components for block grant-funded programs.

QIPE in OSEPHI provides support in the preparation and submission of the MCH Services Block Grant application and report.

Other divisions, centers, and offices within DHSS which continue to play vital roles in supporting a comprehensive set of services for targeted Title V populations in Missouri are:

-Division of Senior Services and Regulation, Section for Health Standards and Licensure, Bureau of Child Care
-Division of Environmental Health and Communicable Disease Prevention (EHCDP)
-Department/Program Support Services, Center for Health Information Management and Evaluation (CHIME)
-Office of Epidemiology
-Center for Local Public Health Services (CLPHS)
-Office on Women's Health
-Office of Minority Health and Senior Services
-Division of Administration Services

Attachment

D. OTHER MCH CAPACITY

D.1. MATERNAL AND CHILD HEALTH FULL TIME EMPLOYEES (FTEs)

The number and location of DCH staff with related Title V Block Grant MCH responsibilities are listed in the attached document. This listing includes staff who provide planning, evaluation, and data analysis capabilities.

The number of full-time employees is 121.71 as of May 31, 2005. In addition, there are 11.75 staff outside of DCH, located in Office on Women's Health, Office of Information Systems, State Center, Office of Epidemiology, and the State Public Laboratory who provide support in the policies for women's health, development and maintenance of the databases, statistical reports, etc., and the performance of such tests as the newborn screening tests.

D.2. TITLE V SENIOR LEVEL MANAGEMENT POSITIONS

Paula Nickelson, MEd., is the Director of DCH (the agency responsible for maternal, child, and family health; nutritional health; chronic disease prevention and health promotion; and community health improvement programs and for the preparation of the MCH Block Grant annual plan and application). Ms. Nickelson serves as the Director of the Missouri Title V program and as the Director of the state's Children with Special Health Care Needs program. Ms. Nickelson has a distinguished career in the human services and management fields. Her experience in mid-Missouri includes roles as the Chief of the former Bureau of Family Health, Director of Clinical Services for the Rusk Rehabilitation Center, and Director of Evaluation and Counseling for Advent Enterprises, Inc.

Robin Rust, MPA, is the Deputy Division Director for DCH. In December 2002, Ms. Rust came to DHSS as Deputy Division Director for the former Division of Maternal, Child and Family Health. She has a distinguished public service career spanning over 22 years of service with the Department of Social Services. Her experience as Assistant Deputy Director in the Division of Medical Services for policy on fee for service, strong management skills, extensive knowledge of provider and funding systems within the state, and established relationships with many of DCH's external partners are invaluable.

Deborah Goldammer, MA, MPA, is the Section Administrator for the Office of Fiscal Support (OFS) and provides fiscal and budgetary expertise for DCH. OFS processes invoices and contract payments for various sections and programs within the division. Ms. Goldammer has served both the legislative and executive branches of Missouri State Government in various capacities since 1976.

Melinda Sanders, MS(N), RN, Section Administrator for MCFH in DCH, began her work at DHSS in 1998. Ms. Sanders has 26 years of nursing experience, including 12 years as a Family Nurse Practitioner. While at DHSS, Ms. Sanders worked as a Consultant Community Health Nurse for children with special health care needs and Chief of the former Bureau of Genetics and Disabilities Prevention before becoming Section Administrator. Ms. Sanders holds Bachelor of and Master of Science degrees in Nursing from the University of Missouri-Columbia.

Sherri Homan, RN, PhD, is the Section Administrator for OSEPHI in DCH. OSEPHI supports DCH in strategic planning; quality improvement initiatives; program evaluations; coordination of specific grants including MCH Title V Block Grant; public information dissemination; initiation and maintenance of surveillance systems, data management and reporting; and epidemiologic consultations and assistance. Dr. Homan began her work with DHSS in 1986 and has served as Deputy Division Director and as Assistant to the Director for Strategic Planning and Program Evaluation for the former Division of Chronic Disease Prevention and Health Promotion. Dr. Homan

received an Associate Degree in Nursing from Missouri Western State College in St. Joseph, Missouri, and completed her Bachelor's and Master's of Science in Nursing from the University of Missouri. Dr. Homan is a Family Nurse Practitioner and also completed her doctorate at the University of Missouri in the Department of Education.

Nick Boshard, PhD, MPH., is in charge of the Quality Improvement, Planning and Evaluation (QIPE) in OSEPHI. QIPE supports departmental and interagency planning and evaluation to better achieve healthy outcomes for women, infants, children, adolescents, and children with special health care needs through grants development and management (including the Title V Block Grant and the State Systems Development Initiative [SSDI] Grant); program analysis and evaluation; statewide MCH need/capacity assessments; departmental strategic planning; and interagency planning and evaluation. Dr. Boshard has over 20 years of experience in the health field including executive positions with multi-hospital systems, teaching experience with the Graduate Program in Health Services Management (University of Missouri), and public health experience with the Centers for Disease Control (CDC).

MCH epidemiological capacity is enhanced through three full time Public Health Epidemiologists assigned to consult and evaluate MCFH related programs and activities: Pamela K. Xaverius, PhD; Venkata PS Garikapaty, PhD, MPH; and Linda Browning, PhD, MPH, RD.

D. 3. PARENTS OF SPECIAL NEEDS CHILDREN

SHCN has a contract with a LPHA to administer the Family Partnership. Three Family Partners, employed by the LPHA, are paid with SHCN monies. FP members are chosen for their expertise as parents of special needs individuals. FP members participate in making SHCN policies and procedures and provide feedback on SHCN items.

Attachment

E. STATE AGENCY COORDINATION

E.1. STATE ORGANIZATIONAL RELATIONSHIPS

The organization relationships among the state agencies are illustrated in the Missouri Organizational Chart located in the attachment to Section III. State Overview, C. Organizational Structure.

DHSS is a party to several written agreements or memoranda of understanding with other state agencies that support collaborative efforts to serve Title V populations in Missouri. Interagency agreements with other agencies include DSS, DESE, DMH, and DNR. In addition, there are several collaborative efforts with state, local, and private agencies, which illustrate the working relationships among the agencies.

Like other states, Missouri is facing the reality that Medicaid as it currently exists is not sustainable in the long run. A special state commission has been established to assess the future of Medicaid in this state and options to reform Medicaid. That commission will consist of five senators and five representatives from the legislature and several department directors. The Director of DHSS will play a prominent role on this commission and in formulating a commission report that will be communicated back to the General Assembly and the Governor's Office in late November or early December of 2005.

Comprehensive Children's Mental Health Services Initiative was announced in September of 2004 by the Governor's Office, the Missouri Legislature, and DMH and requires state agencies to develop a comprehensive children's mental health services system in Missouri. The initiative will focus greater public attention on state policy for (1) greater mental health parity with physical medical services, (2)

managed care protections for plan members with mental disorders, and (3) greater access to needed medications to treat those disorders.

The Missouri Title V Agency played a leadership role in establishing a blueprint for the development of DMH's comprehensive children's mental health system to include an emphasis on primary prevention. Paula Nickelson, DCH Director, served on the Stakeholders Advisory Committee. Robin Rust, DCH Deputy Director, and Melinda Sanders, MCFH Administrator, served on the Comprehensive Management Team.

DCH's Director and Deputy Director and MCFH Administrator collaborate with the Healthy Start sites in the Bootheel area, St. Louis, and Kansas City and conduct conference calls quarterly. Healthy Start coalitions participated in the five-year Title V Block Grant needs assessment.

DCH is sponsoring an evaluation of the Home Visiting Program in collaboration with DSS and the Children's Trust Fund. The focus of the evaluation is effectiveness of the different models now supported by the state.

DHSS and DMS collaborate in the exchange of program data to monitor quality indicators. DHSS actively participates in the Missouri Medicaid Managed Care Quality Assessment and Improvement Advisory Committee which advises DMS on such areas as appropriate measurable population-based quality indicators, health policy that improves the health status of Medicaid managed care clients, and identification of "best practices" of MCH care.

Collaboration continues among the DHSS SCHN Service Coordination staff, other state agencies, and local communities to identify and help enroll children in Missouri's SCHIP and Medicaid.

Administrative Case Management is provided by a cooperative agreement SHCN maintains with DMS. SHCN authorizes the medical necessity of in-home nursing services and provides Service Coordination for participants in the HCY (Missouri's name for the federal EPSDT) program and the Physical Disabilities Waiver (PDW) for participants over the age of twenty-one.

SHCN has an agreement with the State Disability Determination Unit (DDU) to refer children who apply for SSI to the CSHCN program. Referrals are sent directly to SHCN area offices from the DDU.

SHCN maintained a contract with Missouri Department of Labor, Missouri Assistive Technology Project, to provide assistive technology for families of CSHCN.

The Missouri Brain Injury Association manages the Support Partner Program, a family mentoring program. The state agencies DMH, DSS, DESE/Division of Vocational Rehabilitation, and DHSS/SHCN work in streamlining the intake process and service planning. A common, Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant release of information form has been approved to reduce delays between departments. Common data elements have been identified and agreed upon for use when an electronic solution is available.

OHP has begun a new cooperative effort with DNR to better monitor and intervene with public water systems that are fluoridated but not maintaining optimal level of fluoridation.

GNH coordinates the governor-appointed Missouri Genetic Disease Advisory Committee. The Committee advises DHSS in quality assurance of the delivery of services to Missouri residents with genetic conditions. It has four sub-committees (Newborn Screening, Cystic Fibrosis, Hemophilia, and Sickle Cell Anemia). The sub-committees are comprised of representatives from the treatment centers, providers, physicians, and consumers.

The Missouri Fetal Alcohol Syndrome Action and Care Team (MOFASACT) was developed to have a statewide concentrated focus on FAS for prevention and intervention activities and information sharing among committee members who include UM-C, St. Louis Arc, DMH, and DHSS. The team

meets quarterly. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has offered consultant services for developing a comprehensive plan for FAS prevention in Missouri.

MCFH is teaming up with SIDS Resources, Inc., to disseminate print and electronic messages about placing babies on their backs to reduce the risk of SIDS (Back to Sleep campaign). In February 2005, SIDS Resources completed a project for GNH in DHSS to educate hospital nursery room nurses on Back to Sleep. They are now doing a short term project with GNH to do the same program for the Children's Hospitals and to do the remaining general hospitals. From December 2003 through April 2005, the Safe Sleep Workgroup, chaired by the DHSS and SIDS Resources and included child advocates from around the state as well as the breastfeeding community (La Leche and IBLCE - The International Board of Lactation Consultant Examiners), met to develop a brochure around Safe Sleep. The brochure is currently being printed.

HSF facilitated the original development of Fetal and Infant Mortality Review (FIMR) committees to improve an understanding of the root causes of infant death and promote implementation of evidence-based interventions and solutions. The FIMR program continues through the St. Louis Maternal Child Health Coalition in three zip codes targeted by the St. Louis Healthy Start. Another FIMR program was started in January 2004 in Kansas City through the Kansas City Maternal and Child Health Coalition in the Kansas City region.

School Health in HSF collaborates with DESE on school health initiatives, including guidelines for school health programs and professional development for school nurses.

Adolescent Health in HSF coordinates the statewide Council for Adolescent and School Health (CASH). CASH reflects a broad representation of adolescent and school health affiliations, experience, and expertise representing various public and private agencies, ethnic backgrounds, and geographic areas of the state.

The adolescent health consultation and education contract with Children's Mercy Hospital for Adolescent Medicine Consultation Services supports the services of an Adolescent Medicine Consultant, training, technical assistance, and a newsletter "Adolescent Shorts," sent to 6500 adolescent health and mental health professionals statewide. The Adolescent Medicine Consultant represents the DHSS on various advisory groups and responds to requests for technical assistance on adolescent and school health issues, including school-based health centers.

Injury and Violence Prevention within HSF coordinates the Missouri Injury Control Advisory Committee, which serves as a forum for addressing injury issues and provides guidance regarding injury prevention initiatives and activities conducted in the state. This Committee has representation from state, local, public and private agencies and professionals with injury expertise. Injury and Violence Prevention worked with ,the Committee to generate the baseline data for the "State Injury Prevention Report Card" and to design the report, Injuries in Missouri: A Call to Action.

Injury and Violence Prevention serves as the lead agency for the Missouri SAFE KIDS Coalition and support of eight SAFE KIDS coalitions around the state. The coalitions seek to reduce accidents and injuries to children as a result of motor vehicle accidents, falls, drownings, bicycle accidents, fires, recreational injuries, and poisoning and support car restraint and helmet interventions to prevent and reduce injuries associated with auto accidents. Block grant funding was used to generate additional contract support for SAFE KIDS coalitions throughout Missouri.

The work of the State Infant Mortality Work Collaborative (SIMC) involves close collaboration with the March of Dimes, health practitioners, and other statewide agencies and coalitions to identify ways to improve the health and well being of infants in Missouri.

E.2. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)/COMMUNITY HEALTH CENTERS

PRIMO (Primary Care Resource Initiative for Missouri) program which receives funding from the

Health Access Incentive Fund (HAIF) has assisted in expanding dental services through the FQHCs. FQHCs work closely with DHSS Office of Minority Health and Senior Services to address access and disparity health issues. Many of the individuals touched by DHSS's programs, including TEL-LINK and home visiting programs, are referred to FQHCs for medical and dental care.

E.3. LOCAL PUBLIC HEALTH AGENCIES (LPHAs)

DHSS contracts with 109 LPHAs to promote and improve the health of families within their jurisdictional areas. These funds are to be used solely to benefit the residents of Missouri, especially women, infants, children, adolescents, and children with special health care needs. The contracts have community specific interventions with over 250 short term outcomes to reach the Healthy People 2010 objectives.

E.4. TERTIARY CARE CENTERS

SHCN has contracts with approximately 600 providers. Through the use of participating provider agreements with tertiary care centers, pre-approved specialty and sub-specialty care is provided by participating providers for children with special health care needs who otherwise would have no resources for health care services.

GNH has contracts with university affiliated tertiary centers to support infrastructue for statewide program. These centers provide evaluation for genetic conditions, genetic screening, counseling, diagnostic evaluation of genetic conditions and outreach.

E.5. UNIVERSITIES

DHSS continued to contract with Southwest Missouri State University (name will be changed Missouri State University effective August 28, 2005) to provide technical assistance, training, and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs.

A contract with University of Missouri provided for a statewide comprehensive Breastfeeding Educator Program which was presented to an audience that physicians, educators, nurses, lactation consultants, etc. for training in basic lactation management skills needed in every WIC clinic and pediatrician's office.

The Missouri Partnership for Enhanced Delivery of Services (MoPEDS) is facilitated through the Department of Health Psychology in the University of Missouri's School of Health Professions with collaboration assistance from the SHCN. It is developing a coordinated system of care for children with special health care needs in mid-Missouri and is encouraging local partnerships with family, health care providers, schools, and state agencies.

SHCN has contracts with LPHAs and University of Missouri - Mount Vernon to provide service coordination for traumatic brain injury (TBI) patients over the age of 21.

WIC/Nutrition Services' contract with University of Missouri - School Nutrition Education Program provided sequential nutrition education curriculum for pre-K through 12th grades.

E.6. EPSDT

Monthly EPSDT (HCY) reports are available to LPHAs electronically on Mobius hosted on the mainframe at the State Data Center and accessible only to authorized users. HSF is assisting LPHAs in using these reports as related to their MCH contracts in meeting the needs of their constituents.

Title V funds support LPHAs for the purpose of establishing and maintaining an integrated multi-tiered service coordination system capable of addressing targeted MCH issues for the entire MCH population of the state. Health promotion and outreach are two of the major components of the

population-based service level.

E.7. GRANTS AND OTHER COLLABORATIVE RELATIONSHIPS

Early Childhood Comprehensive Systems (ECCS) Grant has been awarded to Missouri to assemble a group of stakeholders to guide the development of a State Plan to create an early childhood comprehensive system. DHSS is using an interagency approach for the leadership of this grant. DHSS, DESE, DMH, DSS, and the Head Start State Collaboration Office form the steering committee for this grant. A larger coalition of stakeholders meets quarterly and includes family members and representatives from the Children's Trust Fund; Citizens for Missouri's Children Crider Center; State Departments of Corrections, Economic Development, Elementary and Secondary Education, Insurance, Mental Health, and Social Services; Family Voices, Fetal and Infant Mortality Review Board, Head Start, Heart of America, Metro Council on Early Learning, Missouri Dental Association, Missouri Primary Care Association, Parent Link, Parents as Teachers, Partnership for Children, Project Life, Ozark Center, Southeast Missouri State University, State of Missouri Governor's Office, United Way, and University of Missouri Hospital and Clinics.

The ECCS Plan for Missouri is structured along a natural continuum from child and family through community and state. It allows for the participants/families to be involved in the identification of their needs and the decision making process identified to meet these needs. The ECCS plan will be included in the state strategic plan.

Several significant achievements have occurred due to the opportunities provided by the Universal Newborn Hearing Screening Grant (continues through March 30, 2006) to ensure diagnosis of congenital hearing loss by three months of age and entry into early intervention by six months of age. Regional representatives were hired to track infants who either missed or failed their initial hearing screening to assure linkage to early intervention services and a medical home. DHSS finalized an agreement with DESE to share aggregate data (e.g. First Steps enrollment, intervention services, type of amplification) on children with a confirmed hearing loss. Further collaboration with DESE is proceeding for sharing specific early intervention information to improve follow-up efforts.

DHSS was awarded FAS prevention CDC funding through September 28, 2008. The grant funds are supporting the development and implementation of the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP). DMH, Missouri Institute of Mental Health, UM-C, St. Louis Arc, and Missouri Primary Care Association are collaborating in this project to reduce alcohol-exposed pregnancies, educate health care providers on FAS, establish FAS centers, and enhance existing surveillance systems.

DCH receives other federal funds, such as the State Systems Development Initiative (SSDI) Grant; Abstinence Only Education funding; Traumatic Brain Injury Grant; Rape Prevention and Sexual Assault Prevention Education Grant; Integrated Comprehensive Women's Health Services Grant; State Oral Health Collaborative Systems Grant; CDC Obesity Grant, and HRSA State Planning Grant to study health insurance coverage (9/1/04 - 8/31/05).

Other funding and collaborative support include: Food Stamp Nutrition Education Program; Nutrition and Physical Activity Program to prevent obesity and other chronic diseases; "Bridging the Gap between Abstinence-Only and Comprehensive Sex Education" conference co-sponsored by DHSS and DESE with public health and education agencies from Kansas and Iowa; Missouri Tobacco Prevention and Cessation Among Women of Reproductive Age Team; partnership of DHSS and DMH in use of state funds and collaborations with community coalitions to generate local in-kind services and resources for first time focus on FAS conferences; Missouri Folic Acid Advisory Council coordination; Breastfeeding Peer Counseling Program.

E.8. FAMILY PARTNERSHIP (FP):

SHCN developed a contract with one LPHA contractor to provide FP services throughout the state.

By contracting with one LPHA instead of adding the FP activities to the CSHCN regional contracts for the 13 regions statewide, SHCN was able to have this LPHA focus specifically on FP activities. Face-to-face meetings, monthly conference calls with FP family members, and quarterly regional newsletters are means to share resource information and training on specific topics relevant to families with special needs individuals. The quarterly newsletters are mailed in both English and Spanish and also uploaded to the FP Web site.

FP members participate in the decision making process for SHCN policies and procedures. In addition, fact sheets, brochures, and forms created by SHCN are distributed to the FP members for feedback.

FP provides outreach activities to encourage participation in the FP meetings. SHCN explored and researched interest groups to assist in the identification and recruitment of youth participation in FP.

F. HEALTH SYSTEMS CAPACITY INDICATORS

F.1. DATA SYSTEMS CAPACITY

Primary source for health data within the state is Center for Health Information and Management Evaluation (CHIME). CHIME oversees the statistical support and health care assurance activities of DHSS; collects, analyzes, and distributes health related information which promotes better understanding of health problems and needs in Missouri, as well as highlighting improvements and progress achieved in the general health status of Missourians. To assure uniform and consistent reporting of all Title V related data, the Title V agency works with CHIME to integrate the eleven core health systems capacity indicators (see the following listing of #01 through #09C) and some of the health status indicators into the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC).

MOHSAIC utilizes a data warehouse augmented with surveillance data such as births, deaths, immunization, hospital patient abstracts, cancer registry, etc. Data fields are configured to allow analytic tools to retrieve data in an aggregated format useful for assessment and policy development purposes. Selected data from the MOHSAIC information warehouse is moved to the DHSS Web page for external users to access.

DHSS Web page provides access to MCH data through the Maternal and Child Health (MCH) Profiles and the Missouri Information for Community Assessment (MICA) system. The MCH Profiles are resource pages that provide information on a specific MCH indicator, including a definition of the indicator, risk factors, description of the condition, intervention strategies, state related programs, community programs and resources, contracts and grants, educational material, studies and reports, and other Web sites pertaining to the MCH indicator.

F.2. HEALTH "SYSTEMS CAPACITY" INDICATORS (HSCIs)

#01 The rate of children hospitalized for asthma (10,000 children less than five years of age).

-- DHSS and DMS collaborate in the exchange of program data to monitor quality indicators. DHSS actively participates in the Missouri Medicaid Managed Care Quality Assessment and Improvement Advisory Committee which advises DMS on such areas as appropriate measurable population-based quality indicators, health policy that improves the health status of Medicaid managed care clients, and identification of "best practices" of MCH care.

--Missouri Asthma Prevention and Control Program (MAPCP) Web site (http://www.dhss.mo.gov/asthma/RelatedLinks.html) provides information and links for schools and child care centers regarding controlling asthma symptoms, preventing most acute asthma attacks, and maintaining desired activity levels. Links are also provided for various publications including the

2005 Missouri state asthma plan and the 2005 Missouri School Asthma Manual. Partners include Asthma & Allergy Foundation of America - Greater Kansas City Chapter, St. John's Health System, Missouri Pharmacy Association, DESE, UAW Ford-Community Health Care Initiatives, American Association of Occupational Health Nurses, Missouri Society for Respiratory Care, Missouri DSS-DMS (Missouri Medicaid), Glaxo-Smith Kline, Sinclair School of Nursing, Missouri DNR-Air Pollution Control Program, DSS-FSD, City of St. Louis City Department of Health, Kansas City Health Department, Missouri School Nurses Association, Children's Mercy Hospital-Kansas City, Tyco Health Services, Truman Medical Center, Missouri Hospital Association, American Lung Association, Missouri School Boards' Association, Kansas City Missouri School District, St. Louis University-School of Public Health, Missouri Primary Care Association, Greater Kansas City Black Nurses Association, Allergy and Asthma Consultants, St. Louis Regional Asthma Consortium, and University of Missouri Outreach and Extension.

--"Improving Missouri School Asthma Services" is a collaborative effort of DHSS, Missouri School Boards' Association, Missouri Association of School Nurses, and University of Missouri - Columbia to equip local school nurses to support children who have asthma, increase awareness and support among school staff and board members, and partner with parents to meet needs of children and reduce disabling effects of poorly controlled asthma.

--American Lung Association of Missouri Asthma (ALAMA) headquarters are in St. Louis and offices are in Kansas City, Cape Girardeau, and Springfield. It offers a variety of programs including Open Airways For Schools, an asthma education program developed by Asthma Research Group of Columbia University's College of Physicians and Surgeons in New York City. It is an interactive asthma curriculum taught to small groups of children with asthma in the third, fourth, and fifth grades to increase children's ability to take care of their asthma on a daily basis. Also offered are Early Childhood Asthma Awareness, a project designed to increase understanding of early childhood asthma among care givers and educators, and Asthma Educator Course that teaches health care providers how to become asthma educators to patients and family members, helping them understand the disease and treatment. The St. Louis Regional Asthma Clinical Research Center with experts from Washington University, St. Louis University, and private practice works with patients to improve the quality of life for asthma sufferers and searches for a cure.

#02 The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

--See Form 17 and #03 below.

#03 The percent of SCHIP enrollees whose age is less than one year who received at least one periodic screen.

--Collaboration continues among the DHSS SCHN Service Coordination staff, other state agencies, and local communities to identify and help enroll children in Missouri's SCHIP and Medicaid.

--CSHCN Service Coordination provides direct service coordination. Program staff are located in SHCN area offices to facilitate the delivery of community-based services and to identify CSHCN, refer these children/families to resources including resources within their communities and provide service coordination and prior authorization activities under the HCY program.

--MCH Coordinated Systems Contracts with LPHAs establish and maintain an integrated multi-tiered service coordination system. Funds are disbursed using an outcome-based contract to local public health agencies with a contractual obligation to use evidence-based interventions. Each jurisdiction is expected to address identified health risk indicators that are the most disparate from the state rate for that indicator. Disease prevention, health promotion, and statewide outreach are major components of the population-based service level. The contracts emphasize local MCH system development or enhancement to address targeted risk factors such as percent of children without health insurance in addition to infant mortality, pregnancy among adolescents ages 15-17, motor vehicle deaths among

children 1-14, inadequate prenatal care smoking during pregnancy, newborns with genetic disorders, and obesity among children.

#04 The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

--Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) has information for pregnant women, their families, and communities on healthy pregnancies and healthy babies. Topics and links include prenatal care and nutrition, MC+ (Medicaid), TEL-LINK which is a free resource and referral telephone line, and WIC.

--The WIC Program prescribes and pays for nutritious foods to supplement the diets of pregnant women, new mothers, infants, and children up to five years of age, who qualify as "nutritionally at-risk," based on a medical and nutrition assessment, and state income guidelines. The WIC Program provides various assistance including medical referrals to health care providers to address the WIC participants needs.

--Campaign ads were developed with the Missouri Broadcaster's Association for messages to promote healthy pregnancy through early and adequate prenatal care.

#05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

--See Form 18.

#06 Percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

--See Form 18.

--October 2003, DHSS was awarded the State Planning Grant from the federal Department of Health and Human Services (HHS) to allow the state to study the issue of the uninsured and to develop a state plan with models and options for increasing access to affordable health insurance coverage for MO residents.

Subsequent to the award of this planning grant, the DHSS/DCH through a contract with the University of Missouri carried out the Missouri Health Care Insurance and Access Survey that was funded with this grant. The survey of 7,000 households conducted in 2004, revealed that about 8.4% of Missouri residents did not have health insurance at the time of the survey. This percentage reflected almost 463,000 Missourians not covered by health insurance. This survey also revealed that about 64,000 of those without health insurance were primarily children whose families earn 300 percent or less of the federal poverty level and parents who earn 75 percent of less of the poverty level who are eligible for insurance coverage but who for whatever reasons are not accessing that insurance coverage.

#07 The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Oral Health Program works with the Elks Mobile Dental Program to provide primary clinical and preventative dental services to CSHCN and other vulnerable children, the Fluoride Mouthrinse Program (FMP) in primarily in areas without access to fluoridated water, and the Water Fluoridation Program. OHP has begun a new cooperative effort with Department of Natural Resources to better monitor and intervene with public water systems that are fluoridated but not maintaining optimal level of fluoridation.

#08 The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program."

--See Form 17.

#09(A) The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

CHIME provides continued integration of multiple single purpose databases into a single system supports a child-centered record. The initial child record is created from the birth records for children born in Missouri. CHIME supports documentation of the services received and/or results of screenings for the child. The system also includes data on immunizations, tuberculosis skin testing, Medicaid status, results of newborn blood spot, newborn hearing screenings results, and blood lead level. Also see the opening paragraphs to this section.

#09(B) The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

--Tobacco use among public high school students in Missouri is monitored through the Youth Risk Behavior Survey conducted every odd numbered spring since 1995 by DESE and funded by the CDC Division of Adolescent and School Health. DHSS Tobacco Use Prevention Program conducted for the first time the Youth Tobacco Survey in 2003 with public middle and high school students, funded by CDC Office on Smoking and Health. Results are in a fact sheet on DHSS Web site, www.dhss.mo.gov/SmokingAndTobacco/youth_use.html.

#09(C) The ability of States to determine the percent of children who are obese or overweight.

OSEPHI is responsible for Pediatric Nutrition Surveillance System (PedNSS) for five years and younger which determines percent of children who are obese or overweight. PedNSS indicators are birth weight, anemia, and breastfeeding. It is funded by WIC.

Below is list of other programs and activities with their descriptions which are, or will be, funded by the MCHBG in Missouri. A list of the HSCIs to which the program/activity applies follows each description.

--Child Care Initiatives - Funds are used to enhance resource and referral (R&R) services for families and CSHCN. Through this project, families may receive technical assistance about how to find appropriate child care for their child with special health care needs and providers receive technical assistance and training to assist them in fully integrating the child into the child care program. Funding will also be used to assure trainers, licensing staff, resource and referral staff, child care health consultants (in local health agencies), and others are trained to deliver services that support child care providers caring for children with special health care needs.
----------HSCI: 2, 3, 6

--Family Partnership - The partnership provides for collaboration of families of CSHCN needs with their communities and provides education and information to community groups through members of that community. Parents and guardians are given the opportunity to offer input and suggestions to impact services used by CSHCN.
----------HSCI: 9a

--MCH Coordinated Systems Contracts with LPHAs - Title V funds support a statewide service coordination network that has been outsourced through community-based contracts with local pubic health agencies and through participating provider contracts with local administrative providers for medical and primary/specialty care services for children with disabilities, chronic illness, and birth defects. Funds are disbursed using outcome-based contracts to local public health agencies with a contractual obligation to use evidence-based interventions. Each jurisdiction is expected to address identified health risk indicators that are the most disparate from the state rate for that indicator. Services include assessment, diagnostic, preventive, and treatment; service coordination provides statewide healthcare support services. Service coordination facilitates, coordinates, monitors, and

evaluates services and outcomes; and encourages an individual/family to develop the skills needed to function at their maximum level of independence.
----------HSCI: 4, 8, 9b, 9c

--Expanded Newborn Screening - Funding will support the implementation of newborn screening using tandem mass spectrometry for fatty acid oxidation disorders, organic acid oxidation disorders, amino acid oxidation disorders, and other potentially treatable or manageable disorders and will support service coordination for children who screen positive for such disorders.
----------HSCI: 3

--CSHCN Service Coordination - The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines. This service focuses on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and provision of service coordination activities for families. Service coordination is provided through 13 regional contracts and by SHCN staff located in area offices throughout the state.
----------HSCI: 1, 2, 3, 6, 7, 8

--Adolescent Health Projects - Title V funding supports the development and implementation of state and community-based projects to promote adolescent health. The Missouri Council for Adolescent and School Health advises the department on priorities for adolescent health initiatives. The Council's priority recommendations for potential funding include projects to more comprehensively address adolescent health through positive youth development and evidence-based strategies. Another statewide strategy is adolescent medicine consultation. Provider education is accomplished through the publication and dissemination of a bimonthly newsletter sent to pediatricians, family practice physicians, advanced practice nurses, and school nurses. Newsletter articles cover a wide range of adolescent health concerns.
----------HSCI: 9b, 9c

--Folic Acid Initiative - This initiative will continue the Missouri Folic Acid Advisory Committee to enhance the work begun to promote awareness of the benefits of folic acid in preventing neural tube defects and continue to develop a three-year plan to reduce neural tube defects by increasing awareness of folic acid in women of child bearing age and address strategies to implement evidence-based interventions to increase consumption of folic acid.
----------HSCI: 8

--Genetic Services - Title V partially funds the program's contributions in the reduction of morbidity and mortality associated with genetic disorders by providing both the public and medical professionals information concerning genetic disorders and the availability of genetic services in Missouri. The genetic disease program maintains a referral network that connects Missourians in need of diagnostic treatment, counseling, and specialized health services with appropriate health care providers.
----------HSCI: 4, 9a

--Healthy Babies - This initiative provides educational materials through the Web site and printed materials that promote healthy pregnancies and healthy birth outcomes and encourages early entry into prenatal care. The Web site (www.dhss.mo.gov/babyyourbaby) will be active through January 2008.
----------HSCI: 4

--Home Visiting - Funds are allocated to Missouri Community-Based Home Visiting Program (MCBHV) and Building Blocks of Missouri to provide home visiting services for pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. MCBHV combines the expertise of nursing, social work, family support work, and education and requires collaboration with other community agencies and programs that also provide home visits to avoid duplication and to fill gaps in services. Building Blocks is an evidence-based prenatal and early childhood nurse home visiting program based on the David Olds' Model (Nurse-Family Partnership). Home visiting services include a health assessment for postpartum mothers and newborns, assessment for risk factors associated

with child abuse and neglect, counseling on child health and development, education on parenting and problem-solving skills, nutrition education, and identification and enhancement of family support systems, as well as referral and case management services.
----------HSCI: 4, 6, 7

--Injury Prevention Projects - Title V funding supports interventions such as addressing child passenger safety, youth violence, and motor vehicle crashes. MCFH works collaboratively with other programs in DHSS, the Division of Highway Safety, SAFE KIDS Coalitions, Think First Missouri, and other state and local organizations to reduce unintentional and intentional injuries through development of a resource guide, community planning, and development of "train the trainer" segments to be incorporated into existing educational programs such as K-12 education, child care, and parent education.
----------HSCI: 8

--Nutrition Projects - Title V funding supports staff in DCH to carry out activities related to assessment, policy and program development, and quality assurance. Funds will target improved nutritional care for children with special health care needs; comprehensive obesity prevention initiatives to impact eating behaviors of families with children and to focus on ways to prevent obesity; increased folic acid use; and breastfeeding in early infancy. Activities will be conducted by multiple divisions and programs.
----------HSCI: 9c

--Outreach and Education: TEL-LINK is partially funded by Title V to support the maintenance of the state's toll-free telephone referral service. This service offers callers information and direct referral to health and health-related services available in local communities and statewide.
----------HSCI: 4, 7

--School Health Capacity Building - Title V and state funding supports the School Health Services program in funding special contracts with public schools, public school districts, and LPHAs to establish or expand population-based health services for school-age children in defined geographic areas. The program focuses on increasing access to primary and preventive health care for school-age children; identifying school-age children with special health care needs and referring them to a system of care; and providing professional education to school health professionals who work with school-age children who may be overweight, at risk for being overweight, or have diabetes, asthma, or ADHD. The program is a collaborative effort of DHSS, DSS, and DESE.
----------HSCI: 1, 9b, 9c

--Coordination and Systems Development - Title V funds are used to support staff in DCH to carry out activities related to assessment, policy and program development, quality assurance, contract monitoring, and program implementation and coordination. Coordination activities between state and local agencies and data collection, analysis and data processing services are also supported with this funding.
----------HSCI: 1-9c

--Epidemiological Services - Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention, and other issues impacting MCH health status.
----------HSCI: 1, 6, 7, 8, 9

--Fetal Infant Mortality Review (FIMR) Development - Funds will continue to be used in supporting and expanding existing FIMR boards in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program, or systems changes which may reduce the rate of fetal infant mortality.
----------HSCI: 4, 5, 6, 9a

--Quality Improvement - Funds will be used to develop and assist in implementing and coordinating the ongoing quality improvement plan and activities for DCH to continually focus on improving the quality of services from Title V programs and contracting agencies. Activities would include evaluation studies, consultation, technical assistance, training workshops, and focus groups. The Missouri Title V agency will continue to seek input from those who use the "MCH system" in Missouri.
----------HSCI: 1-9c

--Program Evaluation - Evaluation of MCH programmatic processes and outcomes has been "mainstreamed" throughout the MCH infrastructure at the state level. Process evaluations assess the extent to which a program or programs are operating as intended. Impact evaluations conducted assess the net effect of a program or programs by comparing program outcomes with an estimate of what would have happened in the absence of the program. Program evaluations supported with Title V funding are a key element in assuring funding is maximized to address MCH issues.
----------HSCI: 1-9c

--Donated Dental Services is a partnership of volunteer dentists with the Missouri Dental Association to provide comprehensive dental care to those among the low-income maternal child health populations in most need of care, at no charge to the patient.
----------HSCI: 7

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Missouri Title V Block Grant Performance Measurement System schematic follows the MCHB system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. Like other states receiving Title V MCH Block Grant funding, Missouri must meet the following requirements:

-Conduct a statewide needs assessment every five years that identifies the need for:
---Preventive and primary care services for pregnant women, mothers, and infants up to age one year;
---Preventive and primary services for children;
---Family-centered, community-based services for children with special health care needs and their families; and
---Review of data and sources of information used to construct the needs assessment.

-For each fiscal year, Missouri and other Title V funded states, will:
---Describe how Title V funds allotted to the State will be used for the provision and coordination of MCH services;
---Assure "maintenance of effort" (i.e., State will maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level provided in FFY 1989);
---Use at least 30 percent of Federal MCH Block funds received for preventive and primary care services for children; and
---At least 30 percent of Federal MCH Block Grant funds received for services for children with special health care needs.

Accountability for Title V MCH Block Grant funding awarded, is also achieved through:

-Measuring the progress towards successful achievement of each individual performance measure;
-Having budgeted and expended dollars spread over all four of the recognized MCH services: direct health care, enabling services, population-based services, and infrastructure building services, and;
-Having a positive impact on MCH outcome measures.

Missouri's priority needs are discussed in Section II, Needs Assessment (5. Selection of State Priority Needs), and Section IV. B, State Priorities. National and State Performance measures are examined in Section II as well as in Section IV. C and D.

The MCH pyramid of "Core Public Health Services Delivered by MCH Agencies" by levels of service serves as a guide for the Missouri pyramid of services.

The two pyramids and the lists of Missouri's 7 priority needs, the 6 mandated national outcome measures, the 18 national performance (NP) measures, and the state performance (SP) measures are in the document attached to this Section IV. A. The NP and SP measures are also listed in Forms 4a and 4b that identify the specific pyramid level of service and key activities for each.

The NP measures are examined in Section IV. C. Also, Form 11 has the report on Missouri's status relative to the 18 NP measures and Missouri's five-year objectives relative to each of these. See Section VII for the NP and SP measure detail sheets.

In FFY 2005, DHSS/DCH completed a five-year MCH needs assessment identifying the need(s) for:

-Preventive and primary care services for pregnant women, mothers, and infants;
-Preventive and primary care services for children; and
-Services for children with special health care needs (CSHCN).

This assessment included but was not limited to the following methods:

-Review of Missouri state profiles compiled by HRSA, CDC, and AMCHP to ascertain external perspectives of MCH needs in Missouri

-Qualitative primary data generated through 12 focus groups conducted throughout Missouri divided into client (user) group and provider or agency group

-Review of CHART survey of local coalition members, state and county profiles (with selected MCH indicators and related priorities) generated by the CHIME and local public health priorities formulated by the CLPHS

-MCH population group(s) forecasts developed from demographic data drawn from the U.S Census and from analysis provided by the Missouri State Demographer's Office

-A composite analysis of selected MCH indicators to compare (county by county) the relative MCH health status of women and children living in different geographical regions in Missouri: infant mortality; unintended pregnancies (teenage pregnancies); tobacco use among mothers during pregnancy; STDs among women of childbearing age; abortions; obesity; percentage of MCH population groups with insurance coverage

-Data provided by the DSS, DMH, MPCA, and other professional associations concerning the infrastructure capacity (in Missouri) to deliver basic health services to MCH population groups

-Nominal group process used by selected MCH stakeholders to suggest possible MCH priorities for Missouri. Stakeholders reviewed a draft version of the assessment presented in this application, reflected upon their own experiences, and developed a ranking of needs that captured the collective thinking of the group.

-An MCH priority setting methodology developed by the Office of Epidemiology and CHIME (MICA priorities) was constructed and applied to data collected for MCH population groups in Missouri.

See Section II, Needs Assessment, for further details.

See Form 16 for State "Negotiated" Performance Measure Detail Sheets. Also included in the Detail Sheets are descriptions of the state selected measures that includes their category on the pyramid, the Missouri goal, the measure used, how the measure is defined, the measure's relationship to Healthy People 2010 (if there is one), data sources and data issues, and the significance of the indicator or why this particular indicator was chosen.

Attachment

B. STATE PRIORITIES

B.1. RELATIONSHIP AMONG PRIORITIES, PERFORMANCE MEASURES, AND HEALTH SYSTEMS CAPACITY INDICATORS

The file attached to this section is a matrix that details the relationship between MCH Title V national and state performance measures, health systems capacity indicators and MCH contract performance measures as well as the relationship (1=highly related, 2=medially related and 3=minimally related) between these performance measures and MCH priorities for the state of Missouri.

Missouri is transitioning from MCH resources (including MCH block funding) now supporting MCH priority needs identified in 2000 to realigning those resources to support MCH priority needs that grew

out of the recently completed MCH Five Year Needs Assessment for this state.

2000 MCH Priority Needs

-- Healthcare Access
-- Prevention of Smoking Among Children and Adolescents
-- Reduction of Unintended Pregnancies
-- Reduction of Child Abuse and Neglect
-- Minority Health Disparities
-- Expanded MCH Information Systems

2005 MCH Priority Needs

-- Early Childhood Development and Education
-- Improve Access to Care
-- Reduce and Prevent Oral Health Conditions
-- Improve Mental Health Status of MCH Population
-- Reduce Obesity Among Children, Adolescents, and Women
-- Reduce Disparities in Birth Outcomes
-- Prevent and Reduce Smoking
-- Reduce Intentional and Unintentional Injuries
-- Enhance Environmental Supports/Policy Development for Prevention of Chronic Disease
-- Reduce Interpersonal/Domestic Violence in MCH Populations

In the MCH Five Year Needs Assessment (2005), Section B.4., Examine MCH Program Capacity of Pyramid Levels, details the state MCH capacity that is currently available to support newly identified MCH priorities for the state of Missouri. The MCH priority need areas established as a result of this assessment will establish a framework for the allocation of Title V MCH block grant funding to support priority need areas such as adequate early childhood development, prevention of smoking, and reduction of obesity. However, the overriding MCH need for Missouri that emerged based upon this assessment was to improve access to care for MCH population groups in Missouri.

B.2. DIRECT SERVICES AND ENABLING SERVICES

Improvement to access to care and reduction and prevention of oral health conditions are goals DHSS is addressing through the Primary Care and Rural Health Unit which works to ensure access to and availability of primary health care services for all of Missouri's populations, such as reducing the shortage of medical professionals and the oral health programs includes collaboration with the Elks' mobile dental units, technical assistance on fluoride mouthrinse program, and community water fluoridation.

Access to health care services in Missouri is contingent upon more than adequate health insurance coverage. Health insurance plans or managed care plans provide "paper benefits" and must be coupled with an adequate supply of qualified health practitioners in all regions of Missouri and infrastructures to reduce geographical or cultural barriers preventing those families from accessing those benefits. Some barriers to adequate access for MCH populations persist relative to the lack of resources necessary to provide care such as community clinics, medical equipment, and practitioners and to a disparity of health resources in underserved areas.

DHSS/DCH, through a contract with the University of Missouri, carried out the Missouri Health Care Insurance and Access Survey. The survey conducted in 2004 was of 7,000 households revealed that about 8.4% of Missouri residents did not have health insurance at the time of the survey. This percentage reflected almost 463,000 Missourians not covered by health insurance. This survey also revealed that about 64,000 of those without health insurance were primarily children whose families earn 300 percent or less of the federal poverty level and parents who earn 75 percent or less of the poverty level who are eligible for insurance coverage but who for whatever reasons are not accessing

that insurance coverage.

--Outside of the I-70 corridor in Missouri, 68% of counties in Missouri are not covered by Medicaid managed care plans and many of these counties have few if any practitioners that accept Medicaid assignment.
-93% of Missouri's counties are designated as Health Professional Shortage Areas (HPSA) for primary medical care services.
-Only 33.9% of Missouri counties have FQHCs in operation that can serve those persons with no insurance or those persons who live in an area with providers that will not accept Medicaid assignment.
-85% of Missouri's counties are designated as Dental Health Professional Shortage Areas (HPSA).

Based upon information from Child and Adolescent Health Measure Initiative, Data Resource Center on Children and Youth with Special Health Care Needs, December 2004, Missouri reported dental care (9.8%), mental health care (13.6%), and specialist care (7.0%) as needed by children with special health care needs but did not receive.

Based upon unweighted estimates from Behavioral Risk Factors Surveillance System (BRFSS), in 2004, 6.7% of Missouri households with children reported having one or more children under 5 years of age who currently has asthma; 12.8% of households with children reported having one or more children 5 to 17 years of age currently has asthma. The American Academy of Allergy, Asthma and Immunology and the Asthma and Allergy Foundation of America ranked the 100 largest metropolitan areas by asthma severity based on prevalence, risk factors, and medical factors. St. Louis was ranked number three and Kansas City was ranked number eight in the nation.

Among the enabling programs to address these issues are home visiting, CSHCN Hope Program, WIC, CSHCN Service Coordination, FP, and HCY

B.3. POPULATION-BASED SERVICES

Interpersonal/Domestic violence against women affects women across all economic, educational, cultural, racial, and religious lines. In 2000, 37,898 domestic violence cases were reported to law enforcement in Missouri; 50 of 88 women murdered were attributed to domestic violence. In 2001, 10% of female high school students in Missouri reported having been forced to have sexual intercourse. In 2001, almost 9% of female high school students in Missouri reported being hit, slapped, or physically hurt on purpose by their boyfriend in the past twelve months.

Reduction and prevention of smoking is priority in Missouri which is ranked tenth in 2003 out of 31 states participating in the Youth Risk Behavior Survey (YRBS) that included the question regarding smoking cigarettes on one or more in the past 30 days in 2003. The Missouri 2003 Youth Tobacco Survey conducted by DHSS in June 2003, determined 43.5% of middle school students and 65.8% of high school students have used some form of tobacco product in their lifetime. Smoking among pregnant females aged 15-19 years was 27.2% in 2001-2002 and overall smoking during pregnancy in Missouri ranked 8th highest among all states.

Reduction in obesity among children, adolescents and women has become a priority. In 2002, the overweight rate for children 2 -5 years of age participating in WIC was 12% which was the 18th highest overweight level in the nation. Data from the Missouri School-Age Children Health Service Program for 5th graders show that 18.5% are overweight. The prevalence of overweight in children in grades 6-8 was 15.9% in 2003, up from 9.1% in 1999. In 2002, the prevalence of overweight high school students was 12%. During the last ten years, the obesity rate among pregnant women in Missouri has increased from 13.8% in 1993 to 21.3% in 2003.

Reduction in disparities in birth outcomes is included as a priority due to the readily apparent disparities between African-Americans and whites. The following statistics from DHSS Community Data Profiles are for 2000-2002. The neonatal death among African-Americans was 10.8 per 1,000

while it was 4.1 per 1,000 among whites. Pre-term birth rate among African-Americans was 17.4 per 1,000 while it was 9.5 among whites. Low birth weight rate among African-Americans was 13.3 per 1,000 while it was 6.8 per 1,000 among whites.

Reduction in intentional and unintentional injuries is another priority. Based on the Missouri Child Abuse and Neglect Calendar Year 2003 Annual Report, the number of children reported as victims of child abuse or neglect in 2003 was 54,581 in 35,452 reported incidents of child abuse and neglect. Of the 9,712 confirmed as abused or neglected, neglect accounted for 44.9%; physical abuse, 24.5%; and sexual abuse, 23.9%. There were 37.5% of the abuse and neglect children who were less than six years old. Of the abuse and neglect fatalities, 80% were under six years of age.

Based on DHSS "Injuries in Missouri: A Call to Action", December 2002, Missouri exceeded the U.S. average in three of the five leading cause of premature death among MCH populations: motor vehicle-related fatalities; suicides; and deaths caused by firearms. In 1998, the 15-19 year old age group had the high rate of death due to motor vehicle accidents in Missouri. The death rate among 15-24 year olds due to motor vehicle accidents in 2003 was 37.1 per 100,000, DHSS MICA.

These priorities are being addressed by programs such as Injury and Violence Prevention, MCH (Local Agency) Services, TEL-LINK Referral Services, School Health, Nutrition and Obesity Education, and Folic Acid and Healthy Babies Education.

B.4. INFRASTRUCTURE SERVICES

The infrastructure building services encompass not only the centralized data collection system but also the surveillance systems and research. The collection, management and dissemination of data on MCH health status, outcomes, process, and structure are key to developing an effective and accountable delivery system serving MCH populations in Missouri. Customized data systems are required to track national and state MCH performance measures. MCH health status indicators need to be integrated within data systems already supported by CHIME partnerships with managed care plans to track and analyze best practice MCH indicators which is another crucial element of Missouri's evolving MCH electronic information system.

In addition, included in the coalitions, surveillance systems, and networks which contribute through collaboration, provision of data, and research are ECCS Coalition, MCH Information Systems, MICA, PedNSS, PNSS, PRAMS, FAS Surveillance System, Infant Morality and Healthy Birth Outcomes research, MCH epidemiological services, women's health networks, and continuous quality improvement teams.

Attachment

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	73	72	70	79	73
Denominator	73	72	70	79	73
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

In 2004, Missouri statutes required for all newborns born in Missouri to be screened for phenylketonuria (PKU), glactosemia, congenital hypothyroidism, congenital adrenal hyperplasia, and hemoglobinopathies.

During calendar year 2004, the State Public Health Laboratory conducted 76,839 initial newborn screening tests and 11,820 repeat newborn screening tests.

Parents of children who had a newborn screen with a presumptive positive newborn result were contacted and asked to either return for a repeat newborn screen or have a confirmatory test done. One hundred percent of the presumptive positive who were confirmed as positive for one of five conditions were entered into a system of health care and placed on a diet or on medication to prevent death, mental retardation, or developmental disability.

DHSS/DCH/MCFH held contracts with four genetic tertiary centers to support infrastructure for a statewide program of genetic services to include genetic screening, counseling, diagnostic evaluation, education, medical referral, treatment services, and outreach. In SFY 2003, the number of individuals receiving services at the four centers for genetic or genetic-related disorders totaled 2,997; while in SFY 2004, the number was 3,021.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All newborns born in MO screened for PKU, galactosemia, hypothyroidism, hemoglobinopathies, and CAH; as of July 1, 2005, there are a total of 27 conditions for which newborns are screened			**X**	
2. Provision by Genetic Tertiary Centers in four university-affiliated medical schools of genetic diagnostic evaluations and counseling, genetic screening, and genetic education		**X**	**X**	
3. Informational pamphlet MISSOURI NEWBORN SCREENING available in English, Spanish, Vietnamese, and Bosnian			**X**	
4. Web sites for Newborn Screening and for Genetics			**X**	**X**
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The newborn screening panel was expanded July 1, 2005, from the current 5 conditions to 27 (including the current 5) of the 29 newborn screen conditions recommended by the March of Dimes and the American College of Medical Genetics. The conditions pertain to amino acids disorders, fatty acid oxidation disorders, and organic acid disorders. The newborn screenings are accomplished using tandem mass spectrometry.

Information will be placed on DHSS's Genetics and Newborn Web site (http://www.dhss.state.mo.us/NewbornScreening/). The MISSOURI NEWBORN SCREENING pamphlet (available in English, Spanish, Vietnamese, and Bosnian) will be revised to add the new conditions.

c. Plan for the Coming Year

The preceding activities and programs will continue in the coming year. Adding conditions, such as cystic fibrosis and biotinadase (the remaining 2 of the 29 conditions recommended by the March of Dimes and the American College of Medical Genetics) may be considered as State Public Health Laboratory capacity allows.

The completion of the new State Public Health Laboratory is anticipated to be in the summer of 2006.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				59.5	61.8
Annual Indicator			57.2	57.2	57.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	64.1	66.6	68.7	70.8	72.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. The projected performance objectives are targeted to the current highest rate nationally (RI 68.6%)

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

A pilot survey of participant satisfaction was conducted in the Springfield area. A summary report of the Springfield area pilot participant satisfaction survey information was analyzed and a baseline of Family Partnership (FP) members by life stage and culture was developed to create a plan for participant/family participation activities.

A Cultural Competency report completed by SHCN and a Title V Community Development Grant Proposal for SHCN were submitted for a pilot in Kansas City and then implemented statewide to increase the culturally diverse participation of families in SHCN decision-making process.

The most prevalent needs expressed in the survey results were the need for resource information, mileage reimbursement (for attendance at face-to-face meetings), regional newsletter (if not able to have face-to-face meetings), and the need or wish to learn more about Medical Home.

By contracting with one LPHA instead of adding the FP activities to the CSHCN regional contracts, SHCN was able to have this LPHA focus specifically on FP activities and implement statewide. The FP provides families with the opportunity to offer each other support and information; gives families the opportunity to provide SHCN input regarding the needs of individuals with special needs; increases public awareness of the issues facing families of individuals with special needs; builds community awareness of the unique needs of individuals with disabilities; promotes state legislation for programs for individuals with special needs and their families. FP members are parents, legal guardians, or siblings of individuals with special health care needs.

This past year, one face-to-face meeting was held with another planned for April 15-16, 2005, as well as monthly conference calls with family partnership family members and quarterly regional newsletters. The quarterly newsletters are mailed in both English and Spanish and also uploaded to the FP Web site, http://www.dhss.mo.gov./FamilyPartnership/Publications.html.

At each activity, resource information is shared. At the face-to-face meetings, in addition to the resource information, training on specific topics relevant to families with special needs individuals is always included. An intensive 2 1/2-day training on Medical Home was offered for 22 participants in April of 2004.

FP participated in the decision making process for SHCN policies and procedures. In addition, fact sheets, brochures, and forms created by SHCN are distributed to the FP members and feedback is encouraged.

Also at the face-to-face meetings, families are reimbursed for lodging, meals, mileage, respite (if needed), and a stipend of $50.00 for their time and participation.

Family Partners (FPs) provide outreach activities to encourage participation in the FP

meetings. SHCN explored and researched interest groups to assist in the identification and recruitment of youth participation in FP.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Cultural diversity surveys to increase culturally diverse participation of families in SHCN decision-making		X		
2. Family Partnership meetings and training		X		
3. Family Partnership in decision making process for SHCN policies and procedures, including fact sheets, forms, etc.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Many of the preceding activities will continue through this current year. FP Initiative will continue statewide.

Plans were made for the evaluation of cultural representation within the FP members.

c. Plan for the Coming Year

The ongoing activities listed above will continue through the coming year.

Results of a statewide participant satisfaction survey and participant/family focus groups will be analyzed and recommendations will be made based on the results.

FP will build a core group of 20 families statewide and involve them in the development and the feedback on documents, forms, fact sheets, newsletters, and the MCH Block Grant application for the next year. FPs will participate in determining Service Coordination competency priorities in contribution to the Service Coordination Contract.

SHCN will provide participants/families with information and resources to assist families in selecting appropriate providers. SHCN will evaluate the availability of SHCN providers and consider the development of focus groups to identify provider issues.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				56.7	58.6
Annual Indicator			55.7	55.7	55.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	59.6	60.6	61.6	62.6	63.6

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. The projected performance objectives are targeted to the current highest rate nationally (MA 61.0%)

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Medical Home core elements were developed for service contractors to identify and assist families in coordinating a medical home. A Medical Home training module was developed and presented to SHCN staff and contracted staff. This module along with a Medical Home fact sheet was developed and will be presented at future Family Partnership meetings.

The Comprehensive Assessment Tool (CAT) was implemented as a mechanism to guide in evaluating a participant's/families' needs and resources. This tool offers the service coordinator a comprehensive view of the needs and contains criteria to identify whether the participant has a Medical Home.

Twenty families from 13 contract regions of the state participated in a Family Partnership meeting to learn more about Medical Home Initiative in Missouri.

SHCN Service Coordinators provided Service Coordination that links families with services and resources to help them maintain the HCY participant safely in their home. Assistance provided included: help with establishing a medical home; referrals for periodic EPSDT Screening Exams; referrals to physicians, therapists, home health agencies, and services; regular home visits to assess family needs; and assistance in assuring that appropriate medical care is being provided through Medicaid.

DHSS/DCH/MCFH contracted with four genetic tertiary cents to support infrastructure for a statewide program of genetic services to include genetic screening, counseling, diagnostic evaluation, education, medical referral, treatment services and outreach. In SFY 2003, the number of individuals receiving services at the four centers for genetic or genetic-related disorders totaled 2,997; while in SFY 2004, the number was 3,021.

Genetic services maintained a referral network to connect Missourians in need of diagnostic treatment, counseling, and specialized health services with appropriate health care providers.

Elks Mobile Dental Program provided primary clinical and preventative dental services for 2366 CSHCN and other vulnerable children in over 3052 encounters. Patients needing comprehensive care were referred to Truman Medical Center with all expenses paid by Elks Lodge.

MOCCRRN assisted families with CSHCN in finding quality child care with support and coordination of services and training, technical assistance, and consultation for child care providers.

School Health Services worked with schools to increase access to primary and preventive health care for school-age children; school-age CSHCN were identified and referred into a system of care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical Home core elements developed; training module presented		X		
2. CAT implemented		X		
3. 20 families participated in meeting regarding Medical Home Initiative		X		
4. SHCN service coordination linked families with services and resources including assistance in establishing a medical home		X		
5. Genetic services provided diagnostic evaluation and counseling for individuals and families at risk for genetic conditions		X	X	
6. Elk's Mobile Dental Units provided primary clinical and preventive dental services for CSHCN and other vulnerable children and referral on Truman Medical Center for more comprehensive care	X			
7. MOCCRRN assisted families with CSHCN find quality child care with support and coordination of services and training, technical assistance, and consultation for child care providers		X		
8. School Health Services worked with schools to increase access to primary and preventive health care for school-age children; CSHCN were identified and referred into a system of care			X	
9.				
10.				

b. Current Activities

Many of the preceding programs/activities are ongoing through the current year.

c. Plan for the Coming Year

The ongoing programs/activities will continue through the upcoming year.

A Medical Home training module was developed and presented to SHCN staff and contracted staff. This module along with a Medical Home fact sheet was developed and will be presented at future Family Partnership meetings.

The peer record review process identifies training issues to be targeted. Service Coordinators are being provided training and a pilot is being implemented on these issues and related activities in assisting families in securing Medical Home access.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				66.6	67.2
Annual Indicator			66	66	66
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	67.8	68.4	69	69.6	70.2

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. The projected performance objectives are targeted to the current highest rate nationally (RI 68.9%)

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Insurance education continued. Families of children with special health care needs have resources available when making decisions about healthcare coverage including the Insurance Fact Sheet and Health Care Plan Features Comparison Checklist. These materials are available on the SHCN Web site and have been distributed to participant/families.

SHCN collaborated with managed care organizations, Systems of Care Board, DSS, DMH, and DESE to obtain information about children with special health care needs that transition within the systems of care.

SHCN surveyed LPHAs and FQHCs to identify gaps in insurance coverage for the special health care needs population to establish processes for SHCN participants/families to apply for

Medicaid to assist in reducing the gaps in coverage.

SHCN surveyed managed care organizations to determine the process used to manage their children with special health care needs populations. The collaboration helped to identify children and offer services or return them to Fee-For-Service if the children did not have on-going special health needs.

Child Care Health Consultation Program connected CSHCN with local resources for comprehensive care.

MOCCRRN provided resource information to each caller including access to health insurance and/or Medicaid.

The Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) provided information for pregnant women, their families, and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including MC+ and financial resources for pregnant women and children. This Web site will remain active through January 2008.

MCH Coordinated Systems had 109 contracts with LPHAs. Each LPHA developed community specific interventions to target risk factors such as children without health insurance.

CHIME provided continued integration of multiple single purpose databases into a single system that supports a child-centered record including Medicaid status.

DHSS/DCH/MCFH held contracts with four genetic tertiary centers to support infrastructure for a statewide program of genetic services to include genetic screening, counseling, diagnostic evaluation, education, medical referral, treatment services and outreach.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Insurance Fact Sheet and Health Care Plan Features Comparison Checklist made available		X		
2. SHCN survey of LPHAs and FQHC to identify gaps in insurance coverage to establish processes for SHCN participants to apply for Medicaid		X		
3. Exchange of information conducted with MCOs, DSS, DMH, and DESE for children transitioning within systems of care		X		
4. Child Care Health Consultation Program connected CSHCN with local resources for comprehensive care		X		
5. MOCCRRN provided resource information to each caller including access to health insurance and/or Medicaid		X		
6. Baby Your Baby Web site provided info for pregnant women, their families,and communities including info on MC+ and financial resources			X	X
7. MCH Coordinated Systems had contracts with LPHAs which developed community specific interventions to target risk factors such children without health insurance			X	X
8. CHIME's child-centered record included Medicaid status				X
9. Genetic Tertiary Centers supported infrastructure for a statewide				

program of genetic services to include genetic screening, counseling, diagnostic evaluation, education, medical referral, treatment services and outreach			X	X
10.				

b. Current Activities

Several of the preceding programs/activities are ongoing through the current year.

c. Plan for the Coming Year

The ongoing programs/activities will continue through the coming year.

MCH Coordinated Sysems contracts will help strengthen the efforts made by LPHAs to target children without health insurance and to assist their families in obtaining public/private health care coverage.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				76.8	78.4
Annual Indicator			75.2	75.2	75.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	81.6	83.2	84.8	86

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. The projected performance objectives are targeted to the current highest rate nationally (ND 83.4%).

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The statewide SHCN Family Partnership (FP) Initiative provided opportunities for communication, advocacy and networking through a family and agency team effort. Family Partners (FPs) participated in regular meetings and discussions to review processes and documents to make suggestions to make items more useful to families and participants with special health care needs.

SHCN developed the Comprehensive Resource Index by using community resources, such as the Chamber of Commerce Web site, and in collaboration with FP, contracted Service Coordinators and Community Connections. It is an index of healthcare and community service providers by life-stage and county and contains contact information and description of each resource.

Participants/families were provided with American Red Cross Disaster Services' "Disaster Preparedness for People with Disabilities". Emergency Response forms are updated annually and maintained within each Area Office to be available during time of an emergency.

SHCN actively participated in local and state disaster response planning activities to represent needs of SHCN participants. Through FP, service coordination, and available data, SHCN identified the most common needs of SHCN participants/families during disasters.

SHCN established and maintained CSHCN Service Coordinator contracts for 13 regions to provide service coordination for children with special health care needs.

The Care Notebook content was finalized to educate participants/families about organizing community-based service systems so they can use them easily and to organize medical information. FPs contributed to the content to assure that the Care Notebooks will be useful for families to whom the Care Notebooks will be distributed.

SHCN initiated the development of a process to improve SHCN provider availability to participants. Location of SHCN participants and location of SHCN providers will be evaluated utilizing a Geographic Information System to identify specific areas to increase efforts of provider recruitment.

SHCN conducted and participated in various case conferences, outreach and site visits, presentations, conferences and teleconferences, meetings, workshops, in-services, and trainings to assure collaboration with external agencies to promote organized community-based service systems. Some examples of collaboration entities include: DESE, DMH, DSS/DMS (Medicaid), WIC, families, FP, hospitals, FQHCs, medical specialty clinics, primary care providers, physicians, dentists, LPHAs, home health agencies, schools, child care providers, child behavioral/parenting support agencies, advocacy agencies, attorneys, Missouri Rehabilitation Center, MoPEDS, emergency management agencies, and community groups.

MCH Coordinated System's outcome-based contracts increased local attention to need for skill building for systems development, effective community collaboration, strategic planning, evidence-based decision-making, social marketing, and outcome evaluation.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FPs participated in regular meetings and discussions to review processes and documents to make suggestions to make items more useful to families and participants		X		

2. Comprehensive Resource Index of healthcare and community service providers was developed		X		
3. Emergency Response forms updated annually		X		
4. SHCN actively participated in local and state disaster response planning activities		X		
5. CSHCN Service Coordinator contracts established for 13 regions		X		
6. Care Notebook content finalized regarding community-based service systems and medical information		X		
7. Process developed to improve SHCN provider availability untilizing Geographic Information System		X		
8. SHCN conducted various activities to promote organized community-based service systems		X		
9. MCH Coordinated System's outcome-based contracts increased attention to systems development and effective community collaboration			X	X
10.				

b. Current Activities

Many of the preceding programs/activities are ongoing through the current year.

The Comprehensive Resource Index is in the process of being revised within each supervisory area.

c. Plan for the Coming Year

Many of the preceding programs/activities are ongoing through the upcoming year.

The SHCN FP will continue statewide. Focus groups will be developed to review processes and documents.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				7.6	9.4
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009

Annual Performance Objective	6	6.5	7	7.5	8

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted. The projected performance objectives are targeted to the current highest rate nationally (ME 14.9%)

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The Comprehensive Assessment Tool (CAT) was revised and finalized after piloted by Service Coordinators. Contracted Service Coordinators and SHCN staff were trained and the CAT was implemented throughout the state. CAT contains a system of "core assessment elements" common to all life stages, with assessment items pertinent to specific life stages. A separate tool was developed for each life-stage and is completed with the Service Coordinator and participant/family on an annual basis CAT contains criteria to identify whether the participant has a Medical Home. CAT and the Service Plan are a standardized way to identify needs of the participant/family, as well as services necessary to make transitions through all aspects of life.

The Transition Plan Form and policy were finalized. The Transition Plan is utilized when participants are transitioning from one life-stage to another, discontinued from a service, and transferred to a new Service Coordinator or new agency. It is utilized to summarize activities to be completed in the Transition Plan and includes domain, transition actions, responsible person (s), expected completion date, actual completion date, and the transition plan participants.

The Life-Stage Transition Guide was also developed to provide outcomes and behavioral indicators to guide transition plan development. The guide includes three domains (healthcare, educational/vocational, and independent living) and can be utilized to identify appropriate milestones for life-stage transitions. Outcome statements for all life stages were developed and integrated into the guide. These serve as benchmarks to identify readiness for transition to next life stage and remaining outcomes needing to be accomplished.

Service Coordinators were trained to use the Transition Plan Policy, Form, and Guide which were then implemented throughout the state. The development of a Transition Planning Worksheet for each life stage began to guide service coordinators in preparing for a transition plan meeting to assure that appropriate members are included.

Transition Satisfaction Survey development was initiated to obtain input from service coordinators, key agencies, and participants/families. The tool will be utilized as a quality assurance measure to determine if transition members are satisfied with the process and to identify possible areas of improvement in relation to transition planning.

Transition Plans were, and are being, monitored. Contracted Service Coordinators keep track of the number of transition meetings held and report the numbers on a monthly basis. SHCN requested a revision of the service coordination software to allow transition tracking to occur electronically.

Staff participated with Senior Services, DMH, Southwest Center for Independent Living, The Whole Person, Vocational Rehabilitation, Missouri Rehabilitation Center, DESE, and schools in

collaborative meetings, conferences, and training activities related to transition issues.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Assessment Tool (CAT) and the Service Plan were used as a standardized way to identify needs of the participant/family and services nucessary to make transitions through all aspects of life		X		
2. Transition Plan was utilized when participants were transitioning from one life-stage to another, and included domain, transition actions, responsible person(s), expected completion date, actual completion date, and the transition plan partiicpants		X		
3. Life-Stage Transition Guide was developed to provide outcomes and behavioral indicators to guide transition plan development		X		
4. Development of a Transition Planning Worksheet began to guide service coordinators in preparing for a transition plan meeting		X		
5. Transition Satisfaction Survey development was intitiated to obtain input from service coordinators, key agencies and participants/families		X		
6. Transition Plans were and are being monitored		X		
7.				
8.				
9.				
10.				

b. Current Activities

Transition Satisfaction Survey development will continue so the tool may be utilized as a quality assurance measure to determine if transition members are satisfied with the process and to identify possible areas of improvement in relation to transition planning.

For monitoring Transition Plans, contracted Service Coordinators are tracking the number of transition meetings held and report the numbers on a monthly basis. SHCN has requested a revision of the service coordination software to allow transition tracking to occur electronically.

c. Plan for the Coming Year

The ongoing activities and programs will continue through the coming year as will the revising and finalizing of the new processes to meet the needs of the participants/families and staff.

SHCN efforts to support multiple collaborative meetings (for transaction activities) will be accelerated.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	86.5	87.1	76	77.1
Annual Indicator	75.7	75.5	73.0	76.4	83.3
Numerator	56958	56901	55720	57522	62614
Denominator	75242	75366	76329	75290	75167
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81.6	83.2	84.8	86.4	88.1

Notes - 2002

Immunization Rate for year 2002 is from the National Immunization Survey Q3/2001-Q2/2002. Immunization rate for 2002 is for the 4:3:1:3:3 series.

Notes - 2003

Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2002-Q2/2003*

Notes - 2004

Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2003-Q2/2004. Revised 2005-2009 performance objectives based on a linear regression of 2000-2004 indicators.

a. Last Year's Accomplishments

Child Care Health Consultants provided technical assistance and consultation on up to date immunizations for children.

The MCH Coordinated Systems involved 109 contracts with LPHAs. Each LPHA developed community specific interventions to target risk factors such as the rate of immunization for two-year olds.

Home visitors from the home visiting programs educated mother/families on the need for immunizations and immunization schedules. The home visitors monitored immunization compliance and assisted families in obtaining a primary care provider. In the Building Blocks Program, 95% of the infants were up to date on all immunizations.

The Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) provided information for pregnant women, their families, and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, immunizations, well child checkups, and special health care needs. This Web site will remain active through January 2008.

TEL-LINK, DHSS's toll-free telephone line for maternal, child, and family health services, provided information and referrals concerning health services including immunizations and Medicaid.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Care Health Consultants provided technical assistance and consultation on immunizations for children		X		
2. LPHAs developed community specific interventions to target risk factors such as immunization for two-year olds			X	
3. Home visiting progrms educated mother/families on the need for immunizations and immunization schedules		X		
4. Baby Your Bay Web site provided information for a wide range of topics including immunizations and well child checkups			X	X
5. TEL-LINK DHSS's toll-free telephone line provides information and referrals concerning health services including immunizations and Medicaid			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The preceding programs/activities are ongoing through the current year.

c. Plan for the Coming Year

The preceding programs/activities are ongoing through the upcoming year.

Plans are for expansion of MOHSAIC, an electronic registry database designed to hold immunization records for all Missouri children.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	29	26.9	24.3	20.6	19.1
Annual Indicator	26.7	23.5	22.2	21.4	21.8
Numerator	3199	2820	2659	2573	2623
Denominator	119869	120012	119928	120094	120094
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	19.6	18.4	17.2	16	14.8

Notes - 2003

Denominators for 2001 and 2002 changed due to new population estimates. The change in denominator altered the 2001 rate previously reported. The 2002 rate was not affected by the change in population estimates.

Notes - 2004

Revised 2005-2009 performance objectives based on a linear regression of 2000-2004 indicators.

a. Last Year's Accomplishments

Health care providers, school personnel, and community leaders reported positive changes in caring for adolescents as a result of receiving education from DHSS adolescent health interventions.

More than 6500 adolescent health providers received education regarding best practices in caring for adolescents.

More than 25,000 adolescents received abstinence education.

Teen pregnancy and birth rates to teenagers 15-17 decreased from 32.5 per 1000 in the year of 2000 to 28.7 per 1000 in the year 2003.

The adolescent medicine and health consultation services contract with Children's Mercy Hospital supported the services of a Board-certified Adolescent Medicine Consultant, training and technical assistance to adolescent health providers, and a newsletter, ADOLESCENT SHORTS, that is sent to over 6500 physicians, advanced practice nurses, school nurses, and interested others. The newsletters provided information on best practices in caring for adolescents. In addition, the Adolescent Medical Consultant provided training on mental health issues in adolescence.

A random sample survey of the newsletter readership indicated that 100% of the respondents said the newsletter was valuable and 88.5% stated that the information from the newsletter was helpful to their practice in caring for adolescents.

In June 2004, the Missouri DHSS and DESE joined public health and education agencies from Kansas and Iowa in co-sponsoring the regional "Bridging the Gap between Abstinence-Only and Comprehensive Sex Education" conference. DHSS sponsored two speakers and provided scholarships to school and community teams across the state that are addressing MCH and School Health contract performance measures to reduce pregnancies and births to teens, ages 15-17 years of age.

The pilot of the Teen Outreach Program (TOP) continued. TOP is a comprehensive youth development approach that has proven effective in increasing school success and protecting youth from risk factors that contribute to teen pregnancy and other negative behaviors. A goal of this pilot is to determine feasibility of replicating this program in Missouri. DHSS contracted with the Wyman Center in St. Louis to provide training and technical assistance to three pilot sites through LPHAs. The pilot sites identified teen pregnancy and graduation from high school as key MCH performance measure priorities.

The MCH Coordinated Systems involved 109 contracts with LPHAs. Each LPHA developed community specific interventions to target such risk factors as the rate of pregnancy among

teens aged 15-17.

TEL-LINK, DHSS's toll-free telephone line for maternal, child, and family health services, provided information and referrals to Missourians concerning health services, such as family planning, prenatal care, prenatal drug abuse, etc.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adolescent medicine and health consultation services contract supported the services of a Board-certified Adolescent Medicine Consultant, training and technical assistance to adolescent health providers, newsletter, and ADOLESCENT SHORTS		X		
2. DHSS and DESE joined public health and education agencies for Kansas and Iowa in co-sponsoring regional "Bridging the Gap between Abstinence-Only and Comprehensive Sex Education" conference		X		
3. Pilot of the Teen Outreach Program (TOP) continued		X		
4. MCH Coordinated Systems had contracts with LPHAs that developed community specific interventions to target such risk factors as the rate of pregnancy among teens aged 15-17		X		
5. TEL-LINK provided information and referrals concerning health services such as family planning, prenatal care, prenatal drug abuse			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Many of the preceding programs/activities are ongoing through the current and upcoming years.

DHSS continues to contract with the Wyman Center in St. Louis to provide training and technical assistance to three pilot sites through LPHAs.

One of the TOP pilot sites is successfully entering into the implementation phase of the pilot and two additional sites were identified to begin the planning phase in FFY 2005.

The Section 510 State Abstinence Education Program served 25,736 adolescents and their families. An outside evaluator was identified to begin conducting an evaluation of the program in 2005.

c. Plan for the Coming Year

Many of the preceding programs/activities are ongoing through the current and upcoming years.

Title V funding will support the development and implementation of state and community based projects to promote adolescent health. The Missouri Council for Adolescent and School Health

(CASH) will advise DHSS on priorities for adolescent health initiatives including the continuance of the adolescent medicine consultation and the bimonthly professional health newsletter (ADOLESCENT SHORTS).

It is anticipated that the results of the outside evaluation will be used to strengthen the State Abstinence Education Program.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15	14	16.7	14	14
Annual Indicator	11.8	14.0	14.0	14.0	14.0
Numerator	16010	10055	10055	10055	10055
Denominator	136254	71823	71823	71823	71823
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	14	14	14	14

Notes - 2003

Estimates for 2001, 2002 and 2003 are based on a 2001 state survey.

Notes - 2004

Estimates for 2004 are based on a 2001 state survey.

a. Last Year's Accomplishments

Due to the SCHIP expansion, the sealants program was discontinued in 2003. However, the following information is provided in regard to efforts to assure good oral health.

The Elks Mobile Dental Program provided primary clinical and preventative dental services to 2366 special health care needs and other vulnerable children populations in over 3052 encounters.

Other successes of the Elks Program were: reinforced good oral hygiene habits and oral health education for children with special health care needs and mental retardation and developmental disabilities; program data reporting barriers identified and improvements suggested; and referrals of patients needing comprehensive care to Truman Medical Center with all expenses paid by the Elks.

Approximately 92,000 children in 345 Missouri schools participated in the FMR Program.

Dental caries reduction was achieved by exposure to topical fluorides, especially in areas without optimal levels of fluoride in public water systems.

Eighty percent of Missouri population on public water systems had access to fluoridated water systems based on the latest information available from DNR.

OHP began developing a cadre of Registered Dental Hygienists in communities around the state to aid in the development of oral health interventions and to act as liaisons with communities, health professionals, and schools in regard to oral health issues, including public water fluoridation.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Elks Mobile Dental Program provided primary clinical and preventative dental services to special health care needs and other vulnerable children populations	X			
2. Patients needing comprehensive care were referred to Truman Medical Center with all expenses paid by the Elks	X			
3. 92,000 children in 345 Missouri schools participated in the FMR Program			X	
4. 80% of Missouri population on public water systems had access to fluoridated water systems			X	
5. Cadre of Registered Dental Hygienists in communities aided in the development or oral health interventions and acted as liaisons in regard to oral health issues, including public water fluoridation			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Elks Mobile Dental, FMR, and Water Fluoridation Programs are ongoing programs.

Efforts continue to create a system of care using community health care center to provide continuing care to children with special health care needs and mental retardation and developmental disabilities.

By December 2004, the Oral Health Surveillance Project had completed screens in 72 Missouri elementary schools. Almost 5000 children had been screened.

OHP initiated joint efforts with the Missouri Dental Association and DSS/DMS to develop the Missouri Donated Dental Services Program.

c. Plan for the Coming Year

The Elks Mobile Dental, FMR, and Water Fluoridation Programs are ongoing programs. It is anticipated that the Oral Health Surveillance Project results will be submitted and collaboration

will continue with Missouri Dental Association and DSS/DMS in the Donated Dental Services Program.

OHP will work through LPHAs, FQHCs, and school health services to further expand access to dental services for CSHCN.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5	5.7	5.1	4.5	3.9
Annual Indicator	6.0	4.1	4.9	4.8	4.3
Numerator	71	47	56	56	50
Denominator	1180876	1160366	1151149	1160629	1160629
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.3	2.7	2.1	1.5	0.9

Notes - 2003

Denominators changed for 2001 and 2002 as a result of new population estimates, as a result the rates for 2001 and 2002 have changed from those previously reported.

a. Last Year's Accomplishments

$10,000 contracts were offered to eight local SAFE KIDS Coalitions to provide primary injury prevention interventions targeted to children from birth through 14 years of age.

During the FFY04 contract period, the SAFE KIDS Coalitions conducted 467 car seat check up events, inspected almost 3400 child passenger safety seats for proper installation, distributed 1144 child passenger safety seats to families, distributed 105 child booster seats to families, distributed 1975 bicycle helmets, distributed 125 gun safety locks, distributed 219 smoke detectors, and conducted 818 safety and injury prevention events in Missouri.

During FFY04, the SAFE KIDS Coalitions touched the lives of over 54,247 Missourians with safety information and education. In addition, the eight local SAFE KIDS Coalitions trained 96 individuals to inspect and properly install child passenger safety seats.

The injury program contracts with Think First Missouri to provide primary injury prevention interventions for children and adolescents specifically related to preventing head and spinal cord injuries.

During the FFY04 contract period, Think First Missouri conducted 91 school assembly programs in 65 schools across Missouri and provided head and spinal cord safety information to over 16,000 school students between kindergarten and twelfth grade. In addition, Think First Missouri conducted reinforcement activities with 4 schools and 2097 students.

Think First Missouri also provided information about the program and preventing head and spinal cord injuries at 29 different conferences, exhibits, and other events.

Injury prevention staff, in addition to providing the support and oversight for the SAFE KIDS Coalitions and Think First Missouri, also facilitated and staffed the Missouri State SAFE KIDS Coalition and the Missouri Statewide Injury Prevention Advisory Committee, and compiled and analyzed injury data, researched evidence-based interventions, and coordinated injury activities among other DHSS programs and other state and local agencies.

The MCH Coordinated Systems involved 109 contracts with LPHAs. Each LPHA developed community specific interventions to target risk factors such as the rate of motor vehicle deaths among children 1-14.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. $10,000 contracts were offered to eight local SAFE KIDS Coalitions to provide primary injury prevention interventions			X	X
2. SAFE KIDS Coalitions conducted car seat check ups, safety/injury prevention events; inspected child passenger safety seat installation; & distributed child passenger safety seats, child booster seats, bicycle helmets, gun safety locks, & smoke detec			X	X
3. SAFE KIDS Coalitions provided safety information and education and trained individual to inspect and properly install child passenger safety seats			X	X
4. Think First Missouri provided primary injury prevention interventions for children and adolescents specifically related to preventing head and spinal cord injuries at school assembly programs, conferences and exhibits			X	X
5. MCH Coordinated Systems had contracts with LPHAs that developed community specific interventions to target risk factors such as the rate of motor vehicle deaths among children 1-14			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Many of the preceding activities and contracts are ongoing through the current and upcoming years.

c. Plan for the Coming Year

Title V funding will continue to support interventions to address injury prevention including motor vehicle crashes. MCFH will work with Division of Highway Safety, SAFE KIDS Coalition, Think First Missouri, and other state and local organizations to reduce unintentional and intentional injuries.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	64	64	64.5	59.4	60.2
Annual Indicator	57.6	58.8	57.8	64.7	62.4
Numerator	34970	44271	43452	49823	48490
Denominator	60764	75290	75176	76960	77708
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	64.9	66.5	68	69.6	71.1

Notes - 2003

Breastfeeding data is reported by the state health lab.

Notes - 2004

Breastfeeding data is reported by the state health lab via the metabolic screening test. Revised 2005-2009 performance objectives based on a linear regression of 2000-2004 indicators.

a. Last Year's Accomplishments

GNH's Breastfeeding Program was able to identify 62% of the infants were being breastfed at time of hospital discharge in 2004 and that 28% were being breastfed at six months.

Among the interventions were:
-Statewide breastfeeding promotion project to include a media campaign
-Enhancement of the Breastfeeding Peer Counseling program
-Creation of a certified breastfeeding educator program offered to community stakeholders
-Continuation of a Web-based curriculum on breastfeeding available to students studying in the healthcare field
-Participation in the CDC Obesity Grant at DHSS
-Expansion of Lactation Rooms at the DHSS buildings
-Purchase of breast pumps for distribution within WIC Clinics
-Breastfeeding Educator three-day program presented to home visiting staff in May 2004

As a result, the media campaign generated over 35 calls to the state information line or TEL-

LINK requesting more information; Breastfeeding Peer Counseling programs increased from 38 to 42 agencies; number of students that logged on to the Web-based curriculum increased; over 90 participants attended the Certified Breastfeeding Educator course; and the breastfeeding initiation and duration rates met the success indicators outlined in the Strategic Plan of 61% of infants being breastfed at hospital discharge and 28% percent of infants breastfed to at least 6 months of age.

Funds from the Well Child Program were used for the three-day Breastfeeding Education Program in May 2004 for home visiting and prenatal case managers to assist them with promoting breastfeeding to prenatal women and to continue to support women who choose to breastfeed post-partum. The evidence-based program had been well received when previously implemented through the Nutrition Institute.

Missouri Council on the Prevention and Management of Overweight and Obesity compiled a comprehensive plan to prevent and control overweight and obesity in Missouri. Barriers to breastfeeding were studied to form strategies and objectives in the plan through the Missouri Council on the Prevention and Management of Overweight and Obesity and the staff of DCH (HP and GNH Units).

WIC/NS Breastfeeding Educator Program trained nearly 100 health professionals and primary care providers in basic lactation management skills needed in every WIC clinic and pediatrician's office.

The home visiting programs provided breastfeeding education to clients whom they saw for prenatal services; provided breastfeeding support for post-partum clients; referred mothers to lactation consultants as indicated; and provided incentives for mothers who chose to breastfeed. In the Building Blocks Program, 60% of the mothers initiated breastfeeding.

The Healthy Babies initiative and the Baby Your Baby Web site provided education promoting breastfeeding.

Child Care Health Consultants provided technical assistance and consultation for mothers breastfeeding.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide breastfeeding promotion project including media campaign		X		
2. Enhancment of Breastfeeding Peer Counseling Program		X		
3. Breastfeeding Educator 3-day program presented to home visiting staff		X		
4. Continuation of Web-based curriculum on breastfeeding available to students in healthcare field		X		X
5. Participation in CDC Obesity Grant		X		
6. Expansion of Lactation Rooms in DHSS buildings		X		
7. Purchase of breast pumps for distribution within WIC Clinics		X		
8.				
9.				
10.				

b. Current Activities

Many of the preceding activity and programs are ongoing in this current year.

c. Plan for the Coming Year

Breastfeeding Program will be funded by MCHBG to promote and support breastfeeding. Child Care Health Consultants will provide technical assistance and consultation. Healthy Babies initiative will promote breastfeeding.

Home visiting programs will continue to educate prenatal clients on breastfeeding; provide breastfeeding support post-partum; refer mothers to lactation consultants; provide incentives for mothers who choose to breastfeed; attempt to increase number of mothers who breastfeed; educate home visiting staff to improve assistance with breastfeeding and their ability to educate the clients.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20	21	35	96.5	97
Annual Indicator	22.4	26.2	96.1	98.7	99.2
Numerator	17000	19747	73392	75989	77084
Denominator	75963	75290	76366	76960	77708
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99

Notes - 2003

Nunber of children screened is provided by the Newborn Hearing Screening Program as reported by hospitals and birthing clinics.

Notes - 2004

Revised 2005-2009 performance objectives set at 99.0%. There may be annual variations in the percent of newborns who are screened (including indicators > 100.0%) since mothers delivering babies in MO or IL may have their babies screened in MO, or vice versa.

a. Last Year's Accomplishments

The Missouri Newborn Hearing Screening Program (MNHSP) was supported with general revenue funds, HRSA Universal Newborn Hearing Screening grant funds, and funding from the MCH Block Grant. The Universal Newborn Hearing Screening grant continues to March 30, 2006.

Follow-up of babies who missed or failed the hearing screening was managed by Regional Representatives, audiologist consultant service, MOHSAIC case management, and data collection.

The program ensured 77,084 babies were screened for hearing loss, most by one month of age; and thereby identifying hearing loss at an age that allowed entry into early intervention by six months of age or sooner.

Other successes included:
-Training provided for a physician who makes house calls to conduct hearing screens in the homes of the Amish following the birth of a baby at home
-DESE information shared with GNH, though in an aggregate form due to FERPA guidelines

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Missouri Newborn Hearing Screen Program screenings conducted			X	X
2. Physician trained to conduct hearing screens in homes of Amish following birth of baby at the home			X	
3. DESE information shared with MCFH/GNH			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The preceding programs and activities are ongoing through the current and upcoming years.

MNHSP is now working with DESE officials to develop a plan for sharing specific early intervention information with MNHSP in order to improve follow-up efforts.

c. Plan for the Coming Year

The preceding programs and activities are ongoing through the current and upcoming years.

MNHSP also has plans to collaborate with DESE in establish training to Service Point of Entry (SPOE) personnel regarding specific needs of infants with hearing loss so that appropriate referrals are made.

In addition, MNHSP intends to continue its outreach into Mennonite and Amish communities, through training and equipment loans, in order to ensure babies in those communities receive a hearing screen.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11	7.83	6.96	4.7	4.7
Annual Indicator	9.3	6.9	5.0	7.3	8.5
Numerator	136980	98511	69000	103000	120000
Denominator	1472903	1427692	1374000	1406000	1411000
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.1	8.7	8.4	8.1	7.8

Notes - 2002

Source of Data Annual Demographic Supplement March 2002 Table HI05 Health Insurance Coverage Status and Type of Coverage by State for All People: 2001

Notes - 2003

Source of Data Annual Demographic Supplement March 2004 Table HI05 Health Insurance Coverage Status and Type of Coverage by State for All People: 2003

Notes - 2004

Annual performance objectives for 2005-2009 have been revised. Percent of children without health insurance is assumed to continue rising in 2005 and 2006 due to predicted Medicaid cuts, based on a linear regression projection from 2000-2004 data. Beginning in 2007, a reduction in the % of uninsured kids is forecast due to a number of factors: improving economic conditions (continuing decrease in unemployment rates), no further Medicaid cuts, and improved outreach to uninsured kids. The % of uninsured kids is conservatively predicted to drop by 0.3% per year, based on the yearly change seen in past rates from Census Bureau data.

a. Last Year's Accomplishments

Families of children with special health care needs when making decisions about healthcare coverage had resources available including the Insurance Fact Sheet and Health Care Plan Features Comparison Checklist. These materials were and are available on the SHCN Web site and have been distributed to participant/families.

SHCN surveyed LPHAs and FQHCs to identify gaps in insurance coverage for the special health care needs population to establish processes for special health care needs participants/families to apply for Medicaid to assist in reducing the gaps in coverage.

SHCN surveyed MCOs to determine the process used to manage their children with special health care needs populations. The collaboration helped to identify children and offer services or return them to Fee-For-Service if the children did not have on-going special health needs.

Through the Child Care Resource and Referral Network and Health Consultants, technical assistance and consultation were provided in regard to access to health insurance and/or Medicaid.

The School Health Services Program increased access to primary and preventive health care for school-age children and school-age CSHCN were identified and referred into a system of care. Percent of children in school health services program with health insurance increased from 65% to 80%.

WIC continued to refer potential applicants to MC+.

The home visiting programs educated clients on the availability of no cost and low cost MC+ healthcare coverage for children, their parents, and pregnant women.

The Baby Your Baby Web site had information for pregnant women, their families, and communities on healthy pregnancies and healthy babies and included a wide range of topics including MC+ and financial resources for pregnant women and children. The site will remain active through January, 2008.

MCH Coordinated Systems contracted with LPHAs. Each LPHA developed community specific interventions that included services coordination and targeted such risk factors as children without health insurance.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Insurance Fact Sheet and Health Care Plan Features Comparison Checklist made available on SHCN Web site and distributed to participants/families		X		
2. SHCN survey of LPHAs and FQHC identified gaps in insurance coverage to establish processes for SHCN participants to apply for Medicaid		X		
3. SHCN surveyed MCOs		X		
4. MOCCRRN and Health Consultants' technical assistance and consultation to access health insurance and/or Medicaid provided		X		
5. School Health Services Program increased access to primary and preventive health care and CSHCN identified and referred into a system of care			X	
6. WIC referrals made to MC+		X		
7. Home visiting programs educated clients of no cost and low cost MC+ healthcare coverage		X		
8. Baby Your Baby Web site included MC+ and financial resources for pregnant women and children			X	X
9. MCH Coordinated Systems contracted with LPHAs that developed community specific interventions to target risk factors such children without health insurance			X	X
10.				

b. Current Activities

The preceding programs and activities are ongoing through the current and upcoming years.

c. Plan for the Coming Year

The preceding programs and activities are ongoing through the current and upcoming years.

Efforts will continue to be made to expand contracts with LPHAs for coordination of CSHCN who require access to care through health insurance coverage.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	92	92	92.1	81	81
Annual Indicator	74.6	81.1	81.0	80.3	83.4
Numerator	347779	392745	413182	433644	440307
Denominator	466406	484417	510237	540113	528124
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85.1	86.8	88.5	90.2	91.8

Notes - 2003

Both denominators and numerators are obtained from the Medicaid Management Report for December of the reporting calendar year.

Notes - 2004

Both denominators and numerators are obtained from the Medicaid Management Report for December of the reporting calendar year. Revised 2005-2009 performance objectives based on a linear regression of 2000-2004 indicators.

a. Last Year's Accomplishments

Missouri Child Care Resource Referral Network (MOCCRRN) and Child Care Health Consultants provided technical assistance and consultation regarding access to health insurance and/or Medicaid.

As of SFY04 (ending June 30, 2005), there were 329,000 children enrolled in Medical Assistance for Families - Child; 12,536 children in Foster Care; 105,641 children in Medicaid for Children; 87,280 in SCHIP; and another 12,648 children in other categories. The Medicaid expenditures for each group were $532.1 million; $68.4 million; $228 million; $107 million, and $109 million, respectively.

Two EPSDT reports were provided to LPHAs:
1) a monthly report that included children with MC+ who are eligible for an EPSDT exam that month according to the American Academy of Pediatrics periodicity schedule; and
2) a semi-annual report that included all children eligible for MC+ and the date of the last service for that child paid by MC+ or MC+ for Kids.

The EPSDT reports are now available electronically on the Moibus and accessible by LPHAs. The Mobius that hosts the EPSDT report is a software system from Mobius Management Systems, Inc., and is hosted on the mainframe at the State Data Center. It allows reports normally printed on the mainframe to be viewed electronically without having to print and distribute the paper report. LPHA's are accessing their EPSDT report(s) using their PC and a web browser interface.

These tools were developed in collaboration with DSS-DMS to assist LPHAs in determining which children in their counties were eligible for MC+. With these reports, LPHAs were able to target outreach to assist children and families in accessing care.

School Health Services worked with schools to increase access to primary and preventive health care for school-age children; school-age CSHCN were identified, managed, and referred into a system of care.

TEL-LINK linked families with public health services and the Medicaid recipient help line.

Through the maternal and child health (MCH) services contracts, LPHAs with low rates of EPSDT exams for Medicaid enrollees whose age was less than one year addressed the priority problem by addressing health care system changes that are needed to increase the percentage of one-year-old children that receive at least one initial periodic screen (EPSDT).

CHIME provided continued integration of multiple single purpose databases into a single system that supports a child-centered record. Among the information included was Medicaid status.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SHCN survey of LPHAs and FQHC identified gaps in insurance coverage to establish processes for SHCN participants to apply for Medicaid		X		
2. MOCCRRN and Child Care Health Consultants provided technical assistance and consultation regarding access to health insurance and/or Medicaid		X		
3. EPSDT reports provided electronically to LPHAs allowed LPHAs to target outreach to assist children and familis in accessing care			X	X
4. School Health Services worked with schoools to increase access to health care for school-age children and CSHCN		X		
5. TEL-LINK referred families to public health services and Medicaid recipient helpline			X	X
6. MCH Services contracts allowed LPHAs with low rates of EPSDT exams to address healthcare system changes to increase screenings			X	

7. CHIME provided support for child-centered record including Medicaid status				X
8.				
9.				
10.				

b. Current Activities

Many of the preceding programs/activities are ongoing through the current and upcoming years.

c. Plan for the Coming Year

Many of the preceding programs/activities are ongoing through the current and upcoming years.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1.4	1.4
Annual Indicator	1.4	1.4	1.6	1.6	1.5
Numerator	1104	1069	1188	1245	1186
Denominator	76329	75290	75167	76960	77708
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4

Notes - 2003

The denominator for 1999 has been changed from what was previously reported. The change, however did not affect the rate as previously reported.

a. Last Year's Accomplishments

The home visiting programs educated clients on the need for early entry into and adequate prenatal care; educated clients on the effects of alcohol, tobacco, and other drugs; provided smoking cessation referrals to all mothers who wish to quit smoking; referred mothers who are using alcohol or other drugs to Comprehensive Substance Treatment and Rehabilitation (C-STAR) programs; and assessed clients for domestic violence.

Home visitors for the home visiting program were trained on counseling and supporting pregnant and postpartum women to discontinue smoking utilizing the substance abuse

program supported by American College of Obstetricians and Gynecologists (ACOG).

In the Building Blocks Program, the number of women who smoked during pregnancy was decreased by 25%; 17% decreased the number of cigarettes they smoked; and 100% discontinued the use of marijuana.

In the MCBHV Program, 99% of the mothers delivered infants greater than 1499 grams and 98% of the mothers delivered full-term infants.

WIC provided to WIC prenatal women referrals to substance abuse programs and prenatal care facilities and nutrition education on appropriate weight gain to improve prenatal women/infant outcomes.

To address smoking cessation, training was held for health care providers at six regional sites. Missouri Tobacco Prevention and Cessation Among Women of Reproductive Age Team identified action steps for addressing smoking in women of reproductive age.

The Missouri Fetal Alcohol Syndrome Action and Care Team (MOFASACT) met quarterly to have a statewide concentrated focus on FAS by public and private agencies and university medical center. Educational totes with external messages regarding dangers of perinatal substance use were distributed throughout the state.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting staff educated clients on early prenatal care; effects of tobacco/alcohol/drugs and smoking cessation		X		
2. Missouri Tobacco Prevention and Cessasion Among Women of Reproductive Age Team identified action steps		X		
3. MOFASACT met for statewide focus on FAS; educational totes distributed		X		
4. Statewide FAS surveillance system developed by OSEPHI and HSF		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The home visiting programs educate clients on the need for early entry into and adequate prenatal care and on the effects of alcohol, tobacco, and other drugs; provide referrals for smoking cessation and/or for alcohol or other drugs to C-star programs; and assess clients for domestic violence.

The home visiting programs are working with the National Nursing Consortium on domestic violence to implement more intense training on screening for and intervening in domestic violence situations.

The home visiting programs also work with mothers and families in obtaining a primary care provider; educate mothers on the need for regular examinations and screenings; and monitor emergency room visits and hospitalizations and educate clients to decrease emergency room visits and hospitalizations.

WIC will continue to provide to WIC prenatal women referrals to substance abuse programs and prenatal care facilities and provide nutrition education on appropriate weight gain.

OSEPHI and MCFH/HSF are building a statewide surveillance system to assist in FAS monitoring which will lead to intervention to reduce FAS and in turn impact low birth weight infants.

c. Plan for the Coming Year

The educational totes with external messaging regarding dangers of perinatal substance abuse will be filled with preventive health information for young, pregnant women receiving prenatal care, case management, or smoking cessation counseling will be distributed at selected sites. Totes are printed in English and Spanish.

It is anticipated that the FAS surveillance system will be completed and in a testing phase.

The preceding programs and activities are ongoing programs for home visiting, HSF's totes and substance abuse prevention, and WIC for the upcoming years.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11	11	11	7.7	6.9
Annual Indicator	10.4	9.2	8.5	6.8	9.9
Numerator	43	38	35	28	41
Denominator	413307	412098	411793	412683	412683
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.9	7.6	7.3	6.9	6.6

Notes - 2003

Denominators were changed for 2000, 2001, and 2002. 2000 reflects the census number and 2001 and 2002 reflects new population estimates.

Notes - 2004

Revised 2005-2009 performance objectives based on a linear regression of 2000-2004 indicators.

a. Last Year's Accomplishments

The adolescent medicine and health consultation services contract with Children's Mercy Hospital supported the services of a Board-certified Adolescent Medicine Consultant. The Adolescent Medical Consultant provided training on mental health issues in adolescence.

In October 2004, four regional "Mental Health Issues in Adolescence" workshops were conducted to promote quality mental health care for adolescents. Topics included: 1) depression and suicide; 2) eating disorders; 3) anxiety disorders; and 4) attention-deficit/hyperactivity disorders. Adolescent medicine board-certified physicians who are members of the Missouri Chapter of the American Academy of Pediatrics and the state Council for Adolescent and School Health presented the content and facilitated interactive discussion sessions with participants. Of the attendees, 43% were school counselors or social workers; 33% were school nurses; 17% were community leaders serving youth; and 3% were public health professionals.

A follow-up survey was sent three months following the Mental Health Issues training to participants of the trainings who volunteered to participate in an evaluation to determine if they were able to meet goals related to attending the workshops. Of the responses, 88% stated that they were able to meet their goals regarding addressing adolescent health practices.

The newsletter ADOLESCENT SHORTS provided information on best practices in caring for adolescents including an article regarding adolescents and parental divorce/separation. A random survey of readership indicated 100% found the newsletter valuable and 88.5% stated the information was helpful to their practice in caring for adolescents.

Six school health contractors reached 17 schools with suicide prevention education for staff.

TEL-LINK, DHSS toll-free telephone line for maternal, child, and family health services, provided information and referrals concerning mental health.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adolescent Medical Consultant provided training on mental health			X	
2. Regional Workshops promoted quality mental health care for adolescents			X	
3. Six school health contractors reached schools with suicide prevention education for staff			X	
4. MCH contracts with four LPHAs continued to address suicide prevention			X	
5.				
6.				
7.				
8.				
9.				

10.					

b. Current Activities

Title V funding continues to support the development and implementation of state and community based projects to promote adolescent health.

In the current FFY 2005 MCCH contracts, four LPHAs continue to address suicide prevention. The LPHAs and the intervention approach they are using are:

Cass - Gatekeepers Question, Persuade, and Refer (QPR) training for professionals working with youth in various sets;
Clay - Teachers and counselors working with 5-18 year olds in one school district for suicide prevention;
Cole - Gatekeepers QPR training for faculty and staff in the school setting.
Howard - Gatekeepers QPR training for faculty and staff in the school setting.

c. Plan for the Coming Year

Title V funding will continue to support the development and implementation of state and community based projects to promote adolescent health to more comprehensively address adolescent health through positive youth development and evidence-based strategies.

Plans are to involve DHSS programs, key state agency partners, and Council for Adolescent and School Health (CASH) members in using the System Capacity for Adolescent Health public health improvement tool developed by the Association of Maternal and Child Health Programs (AMCHP) and the State Adolescent Health Coordinators (SAHCN). The intended outcome is an assessment of existing capacity and organizational and environmental supports needed to improve that capacity to coordinate and provide adolescent health programs and services internally and with other state agencies. On site technical assistance is available from AMCHP and the Konopka Institute for Best Practices in Adolescent Health.

Plans are also to continue to participate in the Governor's Substance Abuse Prevention Advisory Committee to develop a strategic framework to support a statewide substance abuse prevention system. Currently, most emphasis is on youth. This effort addresses national and state performance measures related to underage drinking, substance use, tobacco, mental health, injury, violence, and teen pregnancy.

With DHSS and the CASH as the lead, a plan to promote and provide training to support the Healthy People 2010 National Initiative to Improve the Health of Adolescents and Young Adults will be developed and implemented. The DHSS Center for Local Public Health Services has requested that all LPHAs receive training on he National Initiative Guide that promotes best practices. The Guide highlights the 107 national health objectives that impact the health of adolescents and young adults. The release of the Guide is an opportunity to elevate the importance of adolescent health at state and community levels.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	82	82.1	82.5	79.5	79.9
Annual Indicator	81.8	79.6	79.1	78.3	79.0
Numerator	869	828	910	944	886
Denominator	1062	1040	1150	1206	1122
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80.2	80.6	80.9	81.3	81.7

Notes - 2003

Denominators for 1999 and 2000 have been changed. Rates have been adjusted accordingly and are higher for both years than had been previously reported. 1999 from 75.2 o 78.5 and 2000 from 78.7 to 81.8

a. Last Year's Accomplishments

The home visiting programs educated clients on the need for early entry into and adequate prenatal care; educated clients on the effects of alcohol, tobacco, and other drugs; provided smoking cessation referrals to all mothers who wish to quit smoking; referred mothers who are using alcohol or other drugs to Comprehensive Substance Treatment and Rehabilitation (C-STAR) programs; and assessed clients for domestic violence.

TEL-LINK, DHSS's toll-free telephone line (1-800-TEL-LINK) connected callers to various services, including pediatric and delivering hospitals, alcohol and drug abuse treatment centers, community health centers; crisis pregnancy centers, local health departments, mental health centers, and prenatal clinics.

Title V funding supported contracts with four genetic tertiary centers to support infrastructure for a statewide program of genetic services to include genetic screening, counseling, diagnostic evaluation, education, and outreach.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Home visiting programs educated clients on need for early entry into and adequate prenatal care		**X**		
2. TEL-LINK connected callers to LPHAs and prenatal clinics			**X**	**X**
3. Genetic tertiary centers provided genetic screening, counseling, and outreach		**X**		
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The preceding activities and programs are ongoing through the current and upcoming years.

c. Plan for the Coming Year

The preceding activities and programs are ongoing through the current and upcoming years.

Title V funding will support contracts with four genetic tertiary centers to support infrastructure for a statewide program of genetic services to include genetic screening, counseling, diagnostic evaluation, education, and outreach and TEL-LINK access.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	86	86	86.2	86.4	86.6
Annual Indicator	86.1	85.7	86.0	86.6	86.2
Numerator	65714	64552	64673	66641	66979
Denominator	76329	75290	75167	76960	77708
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.8	87	87.3	87.2	87.1

a. Last Year's Accomplishments

In 2004, the Building Blocks of Missouri Program in Kansas City and Southeast Missouri served 292 clients. Each family received an average of 15 visits by a registered nurse. In September of 2004, a third site was added in Springfield, Missouri. The program is funded to serve 100 clients and is housed in the Springfield-Greene County Health Department. The program is funded by a Healthy Communities, Healthy Schools grant awarded to a coalition of community groups in early 2004.

In 2004, the Missouri Community-Based Home Visiting Program decreased to 12 sites when the St. Joseph-Buchanan program dropped from the program. In 2004, the program served a total of 814 mothers and 687 infants. Each family received an average of 10 visits.

The MCH population benefited by receiving home visits by registered nurses (Building Blocks and MCBHV) and lay family support workers (MCBHV) who provided: assessment, education, case management, referrals for services, influence on mother's life course development by continuing education and attaining employment, help to improve relationships with family and friends, development of parenting skills, help to improve environmental health, help to improve health of the mother, and identified and interacted in situations of domestic violence and child abuse and neglect.

In the Building Blocks Program the number of women who smoked during pregnancy was decreased by 25%; 17% decreased the number of cigarettes smoked; and 100% discontinued use of marijuana.

In the Building Blocks Program, 123 women and their infants completed the program through age two of their child; 95% of infants did not experience any developmental delays at 6 months, 94% at 12 and 24 months; 91% of the infants scored above the 10 percentile on language skills; 60% initiated breastfeeding; 95% of the infants were up to date on all immunizations; and 86% of the mothers were not pregnant again prior to 18 months.

In the MCBHV program, 99% of the mothers delivered infants greater than 1499 grams; and 98% delivered full term infants.

A campaign was developed with the Missouri Broadcaster's Association for messages to promote healthy pregnancy through early and adequate prenatal care to be aired over 250 radio stations statewide. First message was aired in Spring 2004 with others to follow.

TEL-LINK, DHSS's toll-free telephone line (1-800-TEL-LINK) for maternal, child, and family health services, provided information and referrals health services including prenatal care.

To improve prenatal women/infant outcomes, WIC provided prenatal care referrals to prenatal women, including teens applying for program services regardless of their eligibility.

The Healthy Babies initiative provided education to Missouri families promoting prenatal care through Keepsake books and other printed materials.

Title V funding supported the Genetic Services Program which provided diagnostic evaluation and counseling services to individuals and families at risk for genetic conditions.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting programs, Building Blocks of Missouri in Kanas City and St. Louis with Springfield added in September 2004		X		
2. Missouri Broadcaster's Association message on 250 radio stations promoted healthy pregnancies through early and adequte prenatal care		X		
3. TEL-LINK referrals for prenatal care made			X	X
4. WIC prenatal referrals made		X		
5. Genetic Services Program diagnostic evaluation and counseling provided		X		
6.				

7.				
8.				
9.				
10.				

b. Current Activities

The preceding programs and activities are ongoing through the current and upcoming years.

c. Plan for the Coming Year

Several of the preceding programs and activities are ongoing through the upcoming years.

Expansion of the home visiting interventions for the high risk population will be continued to assure prenatal care is received in first trimester of pregnancy.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of inadequate birth spacing (less than 18 months).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10.2	10.4	9.9	10.8	10.8
Annual Indicator	10.8	11.0	10.7	10.8	11.2
Numerator	4657	4725	4566	4632	4877
Denominator	43256	42813	42611	42916	43400
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10.8	10.8	10.8	10.8	10.8

a. Last Year's Accomplishments

The home visiting programs educated women on the need for adequate birth spacing and the relationship of birth spacing to mother's health. Women are referred for family planning services as indicated. In the Building Blocks Home Visiting Program, 86% of the mothers were not pregnant again prior to 18 months.

The Healthy Babies initiative, through resources and training, made educational messages supporting the importance of pre-pregnancy planning, healthy pregnancies, healthy babies, and healthy behaviors for children and families available to Missouri families and home visiting agencies. This information was disseminated through a Web site, Keepsake books, and other printed materials. Over 200,000 pieces of literature were distributed. Through 2004, over

121,000 English and Spanish Keepsakes were distributed.

MCH Coordinated Systems had contracts with LPHAs that developed community specific interventions to target risk factors such births with at less than 18 months spacing.

Exhibits at conferences, such as Missouri Show-Me Summit, Salute to Veterans, County Health Fair, National Parents as Teachers, and Healthy Baby Forum included being ready for pregnancy, early and adequate prenatal care, and "Grandparents, You are Important to Your Grandchildren" which provides information to grandparents who in turn can influence women of childbearing age and their families.

TEL-LINK, DHSS toll-free telephone line (1-800-TEL-LINK) for maternal, child, and family health services, provided information and referrals to Missourians concerning health services including family planning.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home visiting programs educated women on need for adequate birthspacing and impact on mother's health		X		
2. Healthy Babies Initiative educated clients on birth spacing through printed materials and a Web site			X	
3. The MCH Coordinated Systems contracts with LPHAs allowed each LPHA to develop community specific interventions to target risk factors such as births less than 18 months apart		X	X	X
4. Exhibits at conferences addressed being ready for pregnancy, early and adequate prenatal care, and grandparents' influences			X	
5. TEL-LINK referrals regarding birth spacing made			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The preceding programs and activities are ongoing through the current and upcoming years.

c. Plan for the Coming Year

This performance measure will not be carried forward for the coming year.

State Performance Measure 2: *Percent of low income children ages 1-11 who consume nutritionally adequate diets.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14.0	16	18	20	22
Annual Indicator	27.0	24.0	22.5	26.1	
Numerator	15605	13413	13113	15204	
Denominator	57796	55886	58278	58278	52828
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	24	26	28	30	32

Notes - 2004

2004 data from Harvard Frequent Food Survey not available. Following data is available in 2004 for 52,828 children in WIC:

Food Category: Percent Meeting Pyramid:
Meat 41%
Breads/Cereals 11%
Milks 87%
Vegetables 22%
Fruit 65%

WIC will no longer be using data from the Harvard Frequent Food Survey.

a. Last Year's Accomplishments

The Healthy Babies initiative provided education to Missouri families with information on healthy behaviors for children and families. This information was disseminated through a Web site, Keepsake books, and other print materials.

The Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) provided information for pregnant women, their families, and communities on healthy pregnancies and healthy babies including nutrition, special health care needs, and WIC. The Web site will be available through January 2008.

Activities/Interventions of the School Health Program included:
-Professional education targeted to school health professionals who work with school-age children that may be overweight or at risk for overweight or have diabetes, asthma, epilepsy, or ADHD.
-School policies and practices assessed for physical activity, healthy eating, and tobacco-use prevention using the CDC School Health Index.
-Survey of all school districts conducted for current screening practices related to vision, hearing, oral health, scoliosis, blood pressure, height and weight; and compared current practices to evidence-based practices.

WIC and Nutrition Services' School Nutrition Education Program (SNEP) provided Missouri schools access to evidence-based or other quality curriculum to use for teaching nutrition for pre-K through 12th grade. In 2003-2004, Missouri audience expanded to schools in 15 counties

previously not receiving curriculum through SNEP.

A 7-hour statewide training, "Nutrition Services for Children with Special Health Care Needs" was presented by Elizabeth Strickland, MS, RD, CD, to 29 registered dieticians, nurses, case managers, state CSHCN and nutrition program staff, Head Start employees, and WIC nutritionists.

Nutrition Training Institute, of WIC and Nutrition Services, and Child Nutrition Program established and maintained a schedule for providing nutrition training specific to children with special health care needs.

Farmers Market Nutrition Program (FMNP) provided training and educational materials to counties and farmers associated with the expansion of FMNP. Low-income women and children up to age five were provided the opportunity to obtain fresh vegetables and fruits.

Child Care Health Consultants provided technical assistance and consultation on good nutrition for children.

MCH Coordinated Systems contracted with 109 LPHAs. Each developed community specific interventions to target risk factors such as rate of obese children and adolescents.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Babies Initiative provided resource and training to educate families various topics including healthy behaviors for children and families			X	
2. Baby Your Baby Web site provided information on healthy pregnancies and healthy babies including nutritions, special health care needs, and WIC			X	X
3. Professional education targeted school health professionals who work with school-age children who may be overweight, or at risk for overweight, or have diabetes, asthma, epilepsy, or ADHA			X	
4. WIC and Nutrition Services's SNEP provided Missouri schools access to evidence-based or other quality curriculum to use for teaching nutrition pre-K - 12th grade		X		
5. Nutrition Program established and maintained a schedule for providing nutrition training specific to CSHCN		X		
6. FMNP provided training and educational material and allowed for low-income women and children up to age five to obtain fresh vegetables and fruits		X		
7. Missouri Child Care Health Consultants provided technical assistance and consultation on good nutrition for children		X		
8. MCH Coordinated Systems contracts with LPHAs allowed each LPHA to develop community specific interventions to target risk factors such as rate of obese children and adolescents		X	X	X
9.				
10.				

b. Current Activities

Several of the preceding programs/activities are ongoing.

FFY 2005 funds are being used to continue implementation of the intervention started in FFY 2005 with funding from CDC for the Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Disease (NPAO). The Title V funding is expected to complete the first phase and begin the next phase of increasing the number of people involved in the intervention or addressing another level of influence from the Social Ecological Model of Influence and to address another focus area of obesity prevention (breastfeeding, 5 A Day, physical activity, television viewing by children, and dietary determinants).

Formative research was conducted to determine needs of families with children 6 to 18 years of age to achieve and maintain a healthy weight for use in developing and implementing effective interventions.

The Healthy Babies' Keepsake has been made available statewide again in 2005.

Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) has information on healthy pregnancies and healthy babies including nutrition, special health care needs, and WIC.

Child Care Health Consultants provide technical assistance and consultation on good nutrition for children.

MCH Coordinated Systems contracts will continue efforts made by LPHAs which develop community specific interventions to target risk factors such as rate of obese children and adolescents.

c. Plan for the Coming Year

This specific performance measure will not be carried forward for the coming year; however, the priority need related to obesity among children, adolescents, and women will be addressed in the performance measures.

State Performance Measure 3: *Percent of citizens who have access to fluoridated water.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75.0	75.0	75.0	83.1	85.2
Annual Indicator	74.4	80.5	81.5	81.5	79.1
Numerator	3200000	4504144	4589211	4648211	3893120
Denominator	4300000	5595211	5629707	5704484	4923859
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	87.2	89.2	91.2	93.2	95.2

Notes - 2004

Numbers obtained from Department of Natural Resources. Denominator = estimated number of people served by all community water systems in Missouri in 2004. Numerator = number of people in 2004 that are served by water systems that add fluoride, purchase water from a system that adds fluroide, or have natural fluoride levels above 0.6 mg/L.

a. Last Year's Accomplishments

MCH population groups benefit from fluoridated water in the reduction of dental caries, based on "Recommendations for Using Fluoride to Prevent and Control Dental Caries in the United States" from the Morbidity and Mortality Weekly Report (MMWR) Series prepared by CDC (located at www.cdc.gov/mmwr/preview/mmwrhtml/rr5014a1.htm).

The percentage of the population on fluoridated water was maintained during FFY 03 with the percentage of Missouri population on fluoridated public water systems being approximately 80% of the population on public water systems, according to data reported by DNR.

OHP began a new cooperative effort with DNR to better monitor and intervene with the public water systems that are fluoridated, but not maintaining an optimal level of fluoridation.

OHP began developing a cadre of Registered Dental Hygienists in communities around the state to aid in development of oral health interventions and to act as liaisons with communities, health professionals, and schools in regard to oral health issues, including public water fluoridation. These health professionals will champion public water fluoridation in those communities seeking to fluoridate water systems or those facing efforts to discontinue.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Approximately 80% of the Missouri population on public water systems were on fluoridated public water systems			X	
2. New cooperativer effort was developed with DNR to better monitor and intervene with public water systems that are fluoridated but not maintained at optimal level of fluoridation			X	X
3. OHP began developing a cadre of Registered Dental Hygienists in communities around the state to aid in development of oral health interventions, and to act as liaisons			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Preceding programs and activities are ongoing.

c. Plan for the Coming Year

This specific performance measure will not be carried forward for the coming year; however, the priority need related to reduction and prevention of oral health conditions among MCH populations will be addressed in the performance measures.

State Performance Measure 4: *Percent of women who have reported smoking during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17.5	17.9	16.8	17.9	17.7
Annual Indicator	18.3	18.3	18.1	18.1	18.1
Numerator	13955	13761	13607	13895	14083
Denominator	76329	75290	75167	76960	77708
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.5	17.3	17.1	16.9	16.7

a. Last Year's Accomplishments

The home visiting programs improved pregnancy outcomes by helping women practice sound health-related behaviors including decreasing the use of cigarettes, alcohol, and illegal drugs and by improving their nutrition. In the Building Blocks Program, the number of women who smoked during pregnancy was decreased by 25%; 17% decreased the number of cigarettes they smoked; and 100% discontinued the use of marijuana.

Child Care Health Consultants provided technical assistance and consultation on the dangers of smoking and secondhand smoke.

The Baby Your Baby Web site covered a variety of topics including "Why should I quit smoking while I am pregnant?"

Literature funded by Healthy Babies provided educational materials to service providers and Missouri families that included information related to decreasing smoking while pregnant.

The MCH Coordinated Systems contracts with LPHAs allowed each LPHA to develop community specific interventions to target risk factors such as smoking during pregnancy.

School policies and practices were assessed for physical activity, healthy eating, and tobacco-use prevention by using the CDC School Health Index.

Educational totes with external messaging regarding dangers of perinatal substance use were purchased. They were used for carrying educational materials accompanying the infant manikins being distributed statewide, as well as for preventive health information for young, pregnant women receiving prenatal care case management, or smoking cessation counseling at selected sites. Bags were printed in English and Spanish.

DHSS programs targeting women of reproductive age continued collaborating regarding smoking cessation efforts. An evidence-based best practice smoking cessation curriculum titled "5 A's" for integration into clinical practice settings was presented for health care providers at six regional sites.

The Missouri Tobacco Prevention and Cessation Among Women of Reproductive Age Team formed and initiated development of a state plan to address smoking in women of reproductive age.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home visiting programs improved pregnancy outcomes by helping women practice healthy hevaiors including decreasing the use of cigarettes, alcohol, and illegal drugs		X		
2. Child Care Health Consultants provided technical assitance and consultation on smoking and secondhard smoke		X		
3. Baby Your Baby Web site included helpful information on various healthy pregnancy and healthy baby topics			X	X
4. Healthy Babies literature addressed decreasing smoking while pregnant			X	
5. MCH Coordinates Systems contracts allowed LPHAs to target risk factors such as smoking during pregnancy		X	X	X
6. Educational totes in English and Spanish pertaining to dangers of perinatal substance use provided			X	
7. Evidence-based best practice smoking cessation curriculum for clinical practice settings presented to health care providers		X		
8. State Plan to address smoking in women of reproductive age initiated				X
9.				
10.				

b. Current Activities

Several of the preceding programs and activities are ongoing through the current year.

c. Plan for the Coming Year

Some of the preceding programs and activities are ongoing through the upcoming year. This performance measure will be carried forward for the coming year.

State Performance Measure 5: *Percent MC+ Managed Care Organizations (MCOs)*

utilizing MCH data.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	95.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	9	9	7	7	7
Denominator	9	9	7	7	7
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100.0	100	100	100	100

a. Last Year's Accomplishments

DCH continued to participate in DMS MC+ Quality Assurance and Improvement Committee. All managed care plans participating in the MC+ Medicaid program used MCH data to target services to MCH population groups in an attempt to impact the MCH health status indicators.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DCH continued to participate in DMS MC+ Quality Assurance and Improvement Committee				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MC+ Quality Assurance and Improvement Committee continues to function in FFY 2005 as in the past.

c. Plan for the Coming Year

This performance measure will not be carried forward for the coming year.

State Performance Measure 6: *Percent of child care facilities receiving health and safety consultation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	22.0	40.0	45.0	40	40
Annual Indicator	38.0	43.1	40.4	27.6	32.8
Numerator	1757	1931	1806	1233	1465
Denominator	4623	4478	4467	4467	4467
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40	40	40	40	40

Notes - 2004

Numerator = number of providers receiving training on special needs children for October 1, 2003 - April 30, 2004.

a. Last Year's Accomplishments

For the time frame of October 2003 through April 2004, the number of parents receiving training on SHCN was 494; community requests for education (media, schools, non-marketing presentations on special needs/inclusion) was 456. The number of children with special needs served was 1384; typical developing children served was 580.

Missouri Child Care Resource and Referral Network (MOCCRRN) provided services for families and children with special health care needs. Through this project the MOCCRRN have qualified inclusion staff in every R&R agency to provide statewide-enhanced services listed below:
--Determination of need for enhanced services for children with special needs.
--Development of a plan of action, in collaboration with the family, to support child care services to a child with special needs. This may include referrals to an inclusive child care program or other appropriate programs or services.
--Referral of all families of children with special needs to Missouri's Early Intervention Programs (First Steps), local Public School District or other appropriate programs or services.
--Offering of technical assistance to licensed, licensed-exempt, and unlicensed child care providers on how to provide quality care for children with special needs in an inclusive setting. This may be by telephone consultation, referral to community based training, community based services, or other services as available.
--Support of community based training to licensed, licensed-exempt, and unlicensed child care providers regarding inclusive child care.

--Support of community awareness of the importance of inclusive child care.

Child Care Health Consultants consulted with and educated child care providers regarding issues around the care of children with special health care needs.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Training on SHCN provided to child care facilities and parents; community requests for education (media, schools, non-marketing presentations on special needs/inclusion) were responded to		X		
2. MOCCRRN consultation provided for child care providers regarding children with special health care needs		X		
3. MOCCRRN provided resource and referral services for families of children with health care/developmental needs and for child care providers serving them		X		
4. MOCCRRN provided technical assistance to child care providers on quality care for children with special health care needs		X		
5. MOCCRRN provided support of community-based training to child care providers regarding inclusive child care		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MOCCRRN and Child Care Health Consultation Program continue training and providing consultation to child care providers and families of the children with health care and/or developmental needs.

c. Plan for the Coming Year

Though this performance measure will not be continued in coming year's performance measures, Title V funds will be used for such activities to enhance resource and referral (R&R) services for families and CSHCN and to assure trainers, licensing staff, R&R staff, child care health consultants in LPHAs, and others are trained to deliver services that support child care providers caring for CSHCN.

State Performance Measure 7: *Percent of tobacco use among children 14-18 years of age.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance	**2000**	**2001**	**2002**	**2003**	**2004**

Data					
Annual Performance Objective	32.5	32.0	31.5	31.0	30.5
Annual Indicator		30.3		24.8	
Numerator		80985		67385	
Denominator		267278		271712	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30.0	29.5	29	28.5	

Notes - 2002

Data for this measure is obtained form the YRBS. Data is reported every two years. The next available year will 2003.

Notes - 2003

Data is an estimate based on the YRBS and the summary of Fall enrollment 2002-03 from the Department of Elementary and Secondary Education.

Notes - 2004

Data for this measure is obtained form the YRBS. Data is reported every two years. The next available year will 2005.

a. Last Year's Accomplishments

School policies and practices were assessed for physical activity, healthy eating and tobacco-use prevention using the CDC School Health Index.

MCH Coordinated System had contracts with 109 LPHAs. Each LPHA developed community specific interventions to target risk factors such as adolescents who smoke.

Tobacco use among public high school students in Missouri was monitored through the Youth Risk Behavior Survey (YRBS) conducted every odd numbered spring since 1995 by the Department of Elementary and Secondary Education (DESE) and funded by the CDC Division of Adolescent and School Health.

DHSS Tobacco Use Prevention Program conducted for the first time the Youth Tobacco Survey in 2003 with public middle and high school students, funded by CDC Office on Smoking and Health. Results are in a fact sheet on DHSS Web site (www.dhss.mo.gov/SmokingAndTobacco/index.html).

Also, Department of Mental Health and DESE Safe and Drug Free Schools Program conducted a biennial alcohol, tobacco, and other drug use survey with 8th and 12th grade students, and other grades optionally by schools.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. CDC School Health Index used to assess school policies and practices for tobacco-use prevention			X	
2. MCH Coordinated Systems contracts allowed LPHAs to develop community specific interventions to target risk factors such as adolescents who smoke		X	X	X
3. Use of tobacco in public high schools was monitored through YRBS, DHSS Youth Tobacco Use Survey; biennial alcohol, tobacco, and other drug use survey by DMH and DESE			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Starting June 1, 2005, Missouri residents will have access to a statewide tobacco quitline, 1-800-QUIT-NOW. The quitline is funded by CDC. The quitline is part of the foundation for Missouri's comprehensive plan to reduce tobacco use.

The YRBS was conducted in the school year beginning September 2004 and ending June 2005.

c. Plan for the Coming Year

Some of the preceding programs and activities are ongoing through the upcoming year. Data from of the YRBS school year 2005 will be available in December 2005. The next YRBS will begin in September 2006 and be completed in June 2007.

This performance measure will be carried forward for the coming year.

E. OTHER PROGRAM ACTIVITIES

TEL-LINK (1-800-TEL-LINK), the toll-free information and referral line for maternal and child health services, provides referrals and may transfer callers immediately to the appropriate agency.

TEL-LINK was promoted in SFY 2004 through king-size bus boards in St. Louis area, statewide radio and television spots, and newspaper and magazine ads in Kansas City, St. Louis, Springfield, and Columbia.

HCY is Missouri's EPSDT program. SHCN, through an inter-agency agreement with DSS/DMS, provides administrative case management and service coordination to those children receiving home-based medically necessary services through Medicaid. This facilitates medical home identification and connection to health providers.

The MCH Coordinated Systems in FFY04 contracted with 109 LPHAs which achieved 252 of 257 annual short-term outcomes. The outcome-based contracts increased local attention to the need for skill building for systems development, effective community collaboration, strategic planning, evidence-based decision-making, social marketing, and outcome evaluation.

The School Health Program offered contracts to school districts with no health services for "capacity building"; surveyed all school districts for current screening practices related to vision, hearing, oral heath, scoliosis, blood pressure, height and weight; compared current practices to evidence-based practices; and revised screening manuals for vision, hearing, and scoliosis based upon best practices.

The state plan to prevent violence against women was completed. Interpersonal violence prevention programs include Sexual Assault Prevention Services, Sexual Assault Victim Services, SAFE-CARE Network, and Rape Medical Examination Program which support activities aimed to improve primary or preventive health services for women and children. Plans are to continue developing SAFE-CARE Network Web application and mentoring program for new SAFE-CARE providers.

MCFH/HSF Perinatal Substance Abuse (PSA) Program with DSS, DMH, DESE, and other public and private partners had provided education on effects of alcohol, tobacco, and other drugs to health professionals responsible for early identification and referral of pregnant women and children affected by drugs of abuse and supported multidisciplinary resource teams in areas where high prevalence of PSA exists. Due to budget constraints, the PSA Program was discontinued.

DHSS was one of five states awarded FAS prevention funding from CDC for September 30, 2003, through September 29, 2008. Funds are supporting development and implementation of MOFASRAPP to reduce the number of alcohol-exposed pregnancies and ultimately reduce the number of children diagnosed with FAS. In July 2004, Central Missouri FAS Center opened and has evaluated and linked children to resources.

Folic Acid Program aims to increase awareness of importance of folic acid intake to help prevent certain birth defects, disease, and health conditions through development, implementation, dissemination, and evaluation of nutrition education materials and information targeted for health professionals, women of childbearing age, minorities, and general public.

Home visits were provided to high-risk, low income pregnant and post partum women by registered nurses (Building Blocks and MCBHV) and lay family support workers (MCBHV) who provided: assessment; education; case management; referrals for services; influence on mother's life continuing education and attaining employmen; development of parenting skills; identification and interaction in situations of domestic violence and child abuse and neglect; and help to improve relationships with family and friends, environmental health, and health of the mother.

In 2003, the FIMR program was funded to provide the opportunity to do an in depth review of fetal and infant deaths and take action within communities to decrease infant mortality. In early 2004, the Bootheel Healthy Start discontinued its FIMR program. However, another FIMR program was started in January 2004 through the Kansas City MCH Coalition in the broad Kansas City region. FIMR continued through the St. Louis MCH Coalition in the zip codes targeted by the St. Louis Healthy Start. The next site for expansion would be the Springfield area.

GNH implemented a PAMR project. Data was collected regarding women who died while pregnant or within one year of termination of a pregnancy in calendar years 1999 and 2003. Data forms, developed by Florida Department of Health and recommended by CDC, were utilized to abstract the data. The Principal Investigator is expected to have the abstractions completed by January 1, 2006.

Office on Women's Health created statewide e-mail communication network to better inform and educate Missourians on important women's health care issues and to increase awareness of legislation and its impact on women's health issues.

OSEPHI was created from the reorganization (merger) of surveillance units from three former divisions into DCH to allow for a higher level of integration of MCH, Nutrition, and Chronic surveillance systems supporting the MCH population groups. Among the surveillance systems are: PedNSS, PNSS, HFFQ, BRFSS, PRAMS, and Cancer Registry.

Epidemiological and analytic support and consultation are provided for chronic diseases, nutrition, and MCH populations. Office of Epidemiology is using the Perinatal Period of Risk Approach (PPOR) model in collaboration with DCH to identify high risk infant mortality/pre-maturity target areas and with MCH coalition partners to focus resources through a STD study and oral health studies.

OSEPHI/QIPE focuses on improving quality of services of MCH programs through internal evaluations, external evaluations by contracting agencies, and assurance that funding is maximized to address MCH issues. The St. Louis University contract provides data analysis for chronic disease surveillance information. Texas A&M University System Foundation is evaluating the Home Visiting Program.

F. TECHNICAL ASSISTANCE

In the previous year's application and report, request for technical assistance (TA) was for an expert consultant to provide consultation and training to the leadership of the Division of Community Health (DCH) to enable the establishment of a new Division vision and mission, as well as consultation and training to adapt to organizational changes brought about by reorganization within the Department of Health and Senior Services.

This year the request of technical assistance will be submitted for an expert team to travel to Missouri to provide consultation and statewide training on mental health as a public health issue to the Maternal Child Health Program and the School Health Services program. The training team will use Bright Futures in Mental Health as the framework.

There is a need to increase public understanding that mental health is an essential and integral part of overall health. Bright Futures promotes a partnership and shared agenda among health professionals, the child and the family; and focuses on improving social, developmental, health and mental health outcomes as part of a seamless system that comprises health, mental health, and education.

Dr. Rochelle Mayer, National Center for Education in Maternal and Child Health, and Ellen Kagen, Communities Can!, Georgetown University, Washington, D.C., are the suggested individuals for the consultation and statewide training.

V. BUDGET NARRATIVE

A. EXPENDITURES

Please refer to Forms 3, 4, and 5

Missouri spent $23,984,045 including $12,159,088 in MCH Block Grant funds towards maternal and child health objectives in federal fiscal year 2004. MCHBG funds were budgeted at $14,418,533. For the total partnership, Missouri spent $2,248,388 less than budgeted.

State funds expended were $10,652,330. State funded programs included direct health care and service coordination for children with special health care needs (CSHCN), alternatives to abortion services, adolescent health, School-Aged Children's Health Services, school nurse training for CSHCN, TEL-LINK phone referral line, genetic services, sickle cell counseling, home visiting, perinatal substance abuse and healthy babies initiatives, newborn hearing screening, the SAFE CARE Network, newborn screening, and core public health assessment and system building. In addition, Medicaid income was earned to provide service coordination, quality assurance activities, and outreach for children and pregnant women.

Missouri budgeted $26.2 million of partnership funds for the FFY 2004 application but spent $24 million. The state continues to require reductions in general revenue funding in order to balance the budget. The Division of Community Health experienced almost $8 million in general revenue reductions in state fiscal year 2004. This included $3.6 million in family planning and $2.6 million in other maternal and child health programs, which were part of the partnership. Alternative matching sources were used to offset some of these reductions. The primary reasons for the expenditures are less than budgeted for the year include:

----Personal Service and the associated fringe due to attrition, holds on filling of positions, delays in hiring a second MCH epidemiologist, continued funding of newborn hearing screening staff by another federal grant, and reorganization of functions resulting in delays in hiring.

----Service coordination for children with special health care needs contracts were not enhanced as planned in FFY 04 because contractors needed to obtain more experience in implementing the new concept.

----Various program lapses in oral health, injury, TEL-LINK, program evaluation, home visiting, expanded newborn screening, school nurse training and adolescent health projects.

Two charts comparing FFY 2004 budget with expenditures are attached.

Attachment

B. BUDGET

B.1. Please refer to the All Other Forms Section VI. Reporting Forms-General Information, A. Forms 1-21, for the required budget forms, Forms 2, 3, 4, and 5. Estimates have been used in providing FFY 2006 budget details. In the case of "types of individuals served" the budget is based upon a percentage of breakdown by program and service area as to which types of individuals are impacted by the services provided. Form 5, State Title V Programs Budget and Expenditures by Types of Service, parallels the pyramid shown on Page 3 of the Attachment to Section IV. Priorities, Performance and Program Activities, A. Background and Overview, that organizes maternal and child health services hierarchically from direct health care services through infrastructure building.

B.2 Other Requirements

B.2.1. Maintenance of Effort

Missouri is in compliance with the maintenance of effort requirements described in Section 505(a)(4). Missouri has maintained and exceeded efforts of the 1989 program year.

B.2.2. Justification

The program budgets take into account the "30-30-10" requirements of Title V. In addition, Missouri uses a fair method to allocate Title V funds among individuals and areas identified as having unmet needs for maternal and child health services. The State uses its MCH Block Grant funds for the purposes outlined in Title V, Section 505 of the Social Security Act.

The FFY 2006 partnership budget is $4 million less than in FFY 2005. The primary reason for this is that Missouri's FFY 04 expenditures from the budgeted amounts were lower than anticipated and brought forward for use in FFY 2005. It is expected that most of this will be spent in FFY 2005 and not available for use in FFY 2006. As a result of this and State general revenue cuts, certain reductions in programs will occur in FFY 2006 partnership including reductions in:

----TEL-LINK,
----Healthy Babies,
----Injury Prevention,
----Breastfeeding initiatives,
----SAFE CARE,
----CHART,
----Farmer's Market.
----Perinatal substance abuse,
----Prenatal case management,
----Well child initiatives,
----Children with special health care needs projects (assistive technology, medical home, staff and contractor training, enhanced service coordination contracts),
----Teratogen services,
----School nurse training, and
----Farmer's Market.

In a recent reorganization, one section and one unit in DCH were eliminated. These were both supported with general revenue and MCH Block Grant. Section management and the CHART program were eliminated. Remaining programs were reassigned to other sections. Also, in FFY 2005, the MCH Block Grant supported the startup of expanded newborn screening. In FFY 2006, this program will be self-supporting and no MCH Block Grant funds will be needed. Limited expansions will also occur in the home visitation program, oral health personal service and incentive payments for local public health contractors.

The Form 4 shows decreases in funding for all categories. Reductions in the pregnant women category reflect general revenue reductions in perinatal substance abuse and prenatal case management quality assurance programs. The large reduction in the infant category reflects the changes in funding for expanded newborn screening and reductions in Healthy Babies and breastfeeding initiatives. Because less State match will be needed in the FFY 2006 budget, the preventive and primary care for children category is budgeted at almost $1 million less in school-age children health services than in FFY 2005 although these funds will still be available and used for this purpose. Also in this category, there are reductions in SAFE CARE, injury prevention, CHART, well child initiatives, and Farmer's Market. The Children with Special Health Care Needs category is lower because of reductions in CSHCN projects and school nurse training. The other category reflects reductions due to reorganization (eliminating one section and one unit) and TEL-LINK.

As with the Form 4, the Form 5 shows a reduction in all levels. Direct care shows a reduction because assistive technology will not be funded. Enabling is lower because of the projects directed toward children with special health care needs that were considered one-time in FFY 05 and will not be

continued in FFY 06 and perinatal substance abuse initiatives. Population-based shows the biggest decrease. Reductions include Healthy Babies, newborn screening, injury prevention, breastfeeding, TEL-LINK, medical home, and Farmer's Market. This is also the level that includes the school-age children's health services match reduction. The infrastructure level includes the reductions for reorganization including the general revenue personal service cuts and related fringe benefits, SAFE Care, and the elimination of the CHART program.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.